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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS†

CALIFORNIA'S MEDICAL QUOTA FOR ARMED FORCES: FEDERAL SECURITY ADMINISTRATOR McNUTT'S REMARKS AT A.M.A. SESSION

Press Dispatches Concerning Administrator McNutt's Speech.—At the Atlantic City session of the American Medical Association on Monday evening, June 8th, and again on Tuesday morning, Hon. Paul V. McNutt, Federal Security Administrator—appointed by President Roosevelt as Director of the U. S. Office of Defense, Health, and Welfare Services—appeared before the A.M.A. House of Delegates, and his remarks received national publicity through the press associations. After perusal of some of the dispatches, a considerable number of physicians felt aggrieved, forgetting probably, that what was especially irritating was not so much what Mr. McNutt said but, rather, the headlines employed by local editors to introduce his comments. The remarks made by Administrator McNutt, as head of the Federal Procurement and Assignment Service, appeared in the *Journal of the American Medical Association* of June 20th, and physicians who are interested should take time to read what he there stated concerning Army, industrial and civilian medical-needs. His statement, "The Army and Navy and war industry areas have not gotten the doctors they need," may be said in a few words to have formed the basis of his other remarks, and should and will be pondered by all citizen groups, physicians included.*

* * *

A Telegram to Major Seeley, Executive Officer.—The editor was among those present at Atlantic City and heard Mr. McNutt's speeches; and in order to make certain that he had not misunderstood some of the figures presented by Mr. McNutt and his representatives, the following wire was sent to Major Sam F. Seeley, Executive Officer of the Federal Procurement and Assignment Service:

(Copy of Telegram)

WESTERN UNION

June 19, 1942.

Major Sam F. Seeley,
601 Pennsylvania Avenue, N.W.,
Washington, D. C.

To emphasize Mr. McNutt's Atlantic City re-

* For some press clippings, see in this issue, on page 97.

marks, we need following information. One, total number of California physicians now in active service in Army. Two, total number of California physicians still needed to meet California's quota at present date. Three, total number of additional California physicians needed for Army by December 31, 1942. Four, average number of California physicians who should enroll each month to permit California to fulfill its quota by December 31, 1942. Kindly send above or related figures.

(Signed) CALIFORNIA AND WESTERN MEDICINE,
By: GEORGE H. KRESS, *Editor,*
450 Sutter, San Francisco.

* * *

Illuminating Reply Concerning California's Quotas.—In reply to this telegram of June 19th, a letter dated June 20th, was received, and that letter appears in its original form on another page in this issue.†† However, as printed below it has been changed by the editor, through additional paragraphs and numberings for greater convenience in reference and in the comments which are made thereon. Major Seeley's reply follows:

(COPY*)

Office for Emergency Management
WAR MANPOWER COMMISSION
Washington, D. C.

Chairman, Paul V. McNutt
Federal Security Administrator
Procurement and Assignment Service for Physicians, Dentists and Veterinarians

June 20, 1942.

Dr. George H. Kress, Editor,
CALIFORNIA AND WESTERN MEDICINE,
450 Sutter Street,
San Francisco, California.

Dear Dr. Kress:

(1) In response to your telegram of June 19, the following round figures should be used as a basis for your calling to the attention of the medical profession of California the necessity of their early participation in the war effort.

(2) California's quota, in addition to interns and residents, is 2600, to be filled by December 31, 1942.

(3) Figures in this office indicate that less than 1000 are now in military service and your quota for the balance of the year is to be not less than 1800.

(4) Dr. Harold A. Fletcher, 490 Post Street, San Francisco, and Dr. Edward M. Pallette, 1930 Wilshire Boulevard, Los Angeles, are responsible as our State Chairmen for Physicians in California, to determine the availability of physicians in that State.

(5) I would emphasize that the majority of physicians of military age—i.e., those under 45, must anticipate military service sooner or later, except in proven instances where they cannot be spared from civil life.

(6) In the majority of the instances, the deferment of a man under 45 can only be considered temporary, and wherever necessary a replacement should be obtained from among those over 45, the women physicians, or those under 45 who have been rejected for military service.

(7) It is the opinion of this office that more than one-half of California's quota must be filled within the next sixty days and that a minimum of 1800 must enter the military service without fail.

(8) Since the question of dependency has practically been eliminated under Selective Service opinions, the remaining cause for deferment is occupational. In those cases where this office considers a man to be available, we feel justified in challenging deferment on an occupational basis. We do not want to have to resort to such a challenge.

(9) We look to the patriotism and enthusiasm of the medical personnel in California to meet this demand on a voluntary basis, and have set July 1, 1942, as the date to which we look forward when an appraisal of the situation will be carefully considered by the Directing Board in determining its future policies.

Sincerely yours,

(Signed) SAM F. SEELEY, M. D.,
Executive Officer,
Procurement and Assignment Service.

Major Seeley's Letter of June 20th should be Read by Every California Physician.—It is to be hoped that every member of the California Medical Association will take time to read Major Seeley's important communication, since he is the Executive Officer of the Federal Procurement and Assignment Service. If perused in conjunction with Mr. McNutt's speech, and also the report of the A.M.A. Committee on Medical Preparedness,* made through its chairman, Ex-president Irvin Abel, it is particularly illuminating as to military and related needs.

* * *

United States Statistics Concerning Available Medical Personnel.—To be in a position better to evaluate the medical problems now facing both the Government and the Medical Profession, it may be in order first to glance at some statistics dealing with the distribution of Doctors of Medicine in the United States, and in California.

Of some 180,000 licensed physicians in the United States at the present time, about 160,000

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

†† See page 91 for original letter.

* (Paragraphing and numbers inserted by Editor for convenience in reference.)

* Printed in Jour. A.M.A., June 20, 1942, on page 650.

are in active practice. Classified according to age, in round numbers about 43,000 of this active group are under 36, while some 38,000 come within the age group, 36 to 44 years. These two classes make a total of about 81,000 Doctors of Medicine who belong to the age-groups from which the personnel of the Armed Services, in greatest part, must be supplied. Of course, all physicians in the up-to-45 group are not available for medical service, because some have physical disabilities, and others are in essential industries or possess other deferment requisites.

* * *

Figures for the State of California.—Referring now to California statistics, there is a total of 12,868 physicians who are licensed,* of whom 10,590 are resident in California, and 2278 living in other States. To this number must be added about 784 additional names, to include California licentiates admitted since the 1941 State Board Directory came off the press (by examination, 487; by reciprocity with other States, 257; and by reciprocity through National Board certification, 40). This would give California a total of 11,374 physicians who are California licentiates living in the State. Again, of some 2464 Doctors of Medicine in California who are under the age of 36, about 592 were in active service at the time of the recent A.M.A. meeting.

* * *

Executive Officer Seeley's Opinion of California's Quota.—Coming back, now, to Major Seeley's letter, in Paragraphs 2 and 3 it is stated that fewer than 1000 California Doctors of Medicine are in active service with the Armed Forces; and that California's total quota of physicians to be supplied—in relation to the total number of licentiates as compared with other States—will require the added induction of 2600 Doctors of Medicine. In other words, a total of about 1800 physicians must be taken from private practice for induction as members of the Medical Corps, between the present date and December 31st of this calendar year.

* * *

Situation as Regards Physicians under the Age of 45.—The real significance of what is involved in the figures just given, however, is sharply outlined in Major Seeley's letter when he states:

(5) I would emphasize that the majority of physicians of military age, i.e., those under 45 must anticipate military service sooner or later, except in the proven instances where they cannot be spared from civil life.

If this declaration had come from a less authoritative source than that of the Executive Officer of the Federal Procurement and Assignment Service, doubt in regard to the needs discussed could easily arise. Received, however, in answer to specific questions, and from the source bureau through which all procurement directives and other information are sent forth, there can be little question concerning the thoughts expressed.

* * *

California not the Only State with Deficient Record.—Furthermore, in a succeeding number of the *Journal of the American Medical Association* (issue of June 27, 1942, page 715), a supplementary statement from Mr. McNutt is given, from which the following paragraphs may be quoted:

. . . In fairness to the recruitment record of many of our states, it seems in order at this time to give the profession some further idea of how its problem is distributed. The failure of a sufficient number of physicians to volunteer for military service is not spread thinly over the whole country. There is an acute lag in certain populous states. Other states have supplied nearly all that they should supply.

We need more than twenty thousand additional physicians by the end of this year. But eight states—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—should account for nearly sixteen thousand of that shortage. . . .

The seriousness of the deficit in the number of physicians available for armed forces should not be underestimated. The need must be met. It will be met by one method or another. Neither must we underestimate the serious drain this puts on available medical services in civilian communities. It will mean long hours and hard work—sacrifices which will multiply the deep debt that every community owes to its physicians. . . .

It is my belief that the lag in recruitment has been due chiefly to the fact that the individual physician has not realized the genuine urgency of the need. Measures must be taken which will bring those needs home to every individual. This means that there will have to be some education of the general public. Preventable illness must be reduced to a minimum. Unreasonable demands on the physician's time must be reduced to a minimum. Thus only may available medical service adequately cover the needs.

* * *

Concerning Dependency and Occupational Deferments.—Equally significant are Paragraphs 6 and 8 of Major Seeley's letter referring to occupational and temporary deferments for physicians of 35 years of age and under. The statements contained therein certainly are worthy of the most serious consideration by all Doctors of Medicine to whom they apply.

(6) In the majority of the instances, the deferment of a man under 45 can only be considered temporary, and wherever necessary a replacement should be obtained from among those over 45, the women physicians, or those under 45 who have been rejected for military service.

(8) Since the question of dependency has practically been eliminated under Selective Service opinions, the remaining cause for deferment is occupational. In those cases where this office considers a man to be available, we feel justified in challenging deferment on an occupational basis. We do not want to have to resort to such a challenge.

* See page 30 of March, 1941, Directory of the Board of Medical Examiners of the State of California.

Request Concerning Needs within Next Two to Six Months.—We feel free to state, under existing conditions, that we do not understand how it will be possible to transfer 900 California Doctors of Medicine from civilian to military status within the next 60 days, i.e., before August 20, 1942.

That, however, does not make the urgency of the need one whit less than actually exists, and it may be assumed that the California Procurement and Assignment Service, acting through the California Chairman, Dr. Harold A. Fletcher of San Francisco (in charge of procurement for the Northern portion of California), and his Associate Chairman, Dr. Edward M. Pallette, of Los Angeles (charged with the responsibility of supervision and coördination of efforts of component county groups in the Southern section of the State), will do all within their power to promote the objectives of the Federal Procurement and Assignment Service.

Certainly, it must be agreed by all members of the Medical Profession that prompt surveys and alignments are now in order, if our Country's Manpower Commission, appointed by President Roosevelt, is to be supplied with the medical personnel so urgently needed for the tasks immediately ahead.

PROPOSED BASIC SCIENCE INITIATIVE FOR CALIFORNIA

California Has Needed a Basic Science Law for Many Years.—For many years, since 1927 in fact, and in these editorial pages, the need of a Basic Science Law, through which the health of the citizens of California would be protected from the services of licensed healing-art practitioners, who do not possess adequate preliminary and other education, and who through improper licensure, otherwise might be called upon to administer to the needs of sick and injured citizens of the State, has been repeatedly commented on.*

Since 1927, as stated, a program of education has been consistently carried on by the California Medical Association, during which period two separate Assembly bills were presented at Sacramento; as try-outs, to learn the reaction on legislative measures through which there might be brought into being in our State, a qualifying certificate board by name, "Basic Science Board," from which would be required a certificate on primary or fundamental education from every applicant for a healing-art certificate, before he or she could be eligible to take an examination by any one of several healing-art boards now existing in California. Therefore, it should be of special interest to all Doctors of Medicine in California to learn that the proposed Basic Science Initiative, sponsored by the California Medical Association, the California State Dental Association, the Southern California State Dental Association, and the Public Health League of California, will actually find a place upon the November, 1942, ballot as one of several initiatives and measures then to be favorably or unfavorably voted upon. Note:—On the ballot, the Basic Science Initiative will have Number 3. Do not forget the number (3).

* * *

Basic Science Initiative will be on November Ballot: Then What?—This last statement concerning possible non-approval by the voters of California is made with a triple purpose:

(1) To permit the members of the California Medical Association to know that their Basic Science Initiative will be on the November, 1942, ballot;

(2) To inform them that the invidious and confusing "Basic Subjects Act"*, sponsored by certain Chiropractic groups, will not be on the ballot—not a single county in California having presented Chiropractic petitions to the Secretary of State. (Whether these are being held back for some future years, is not known at this time);

(3) To acquaint members of the California Medical Association concerning the heavy work and tasks yet to be done.

It may be well for non-sectarian practitioners of the healing-art, i.e., those of us who call ourselves regular Doctors of Medicine, to reflect for a few minutes on certain principles to which our own group of non-sectarians have always given allegiance.

* * *

Some of Our Tenets.—For, speaking of ourselves, we may state:

(a) We approach the practice of healing-art with open minds, and without preconceived notions or dogmas concerning the causation or course of diseases or injuries; and according to our teachings, we are permitted to use anything and everything that may make for the prevention or cure of disease or injury, so long as its administration does not promote personal or group profit or aggrandizement to the detriment of the public health.

(b) We decry and oppose, as unscientific and irrational, the postulates of all healing-art practitioners, no matter to whose group or cult they belong, who espouse or promote, before the public, those healing-art methods that are a contradiction to common sense or other logic.

(c) We believe, and hope that our lay fellows also hold, that every healing-art practitioner, no matter to what group he or she may belong, who himself stands before the public as a healing-art practitioner, and licensed by the State as such, shall and must possess at least a minimum preliminary education, to indicate that when he pursues his professional training, he shall have at his disposal a background of basic or primary knowledge, that will permit State Licensing

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* For those who wish references, see CALIFORNIA AND WESTERN MEDICINE, issue of August, 1941, on page 104.

* For photostatic copies of misleading allurements, see CALIFORNIA AND WESTERN MEDICINE, April, 1942, on pages 228-229.

Boards in the Healing-Arts certain assurance, that no matter what be his views concerning treatment measures, he shall still have had sufficient fundamental or preliminary education to demonstrate an adequate knowledge of the nature, course and treatment of human diseases and injuries.

In other words, bluntly put, and in reverse, the great State of California, has no right to place in the care of *incompetent* practitioners of the healing-art, the health and lives of its citizens. If life is sacred, as our many criminal laws suggest, why should it not be safeguarded, likewise, from incompetent practitioners? It is quite true, that legislatures not infrequently, in response to specious pleas, do enact improper licensure regulations—these in spite of the protests of scientific medicine;—but such action is largely a reflection on all who are guilty of such acts, and must not be cast in reproach upon those who protested the submitted legislation.

In making these statements, there is no vindictiveness. Not to portray these fundamental facts, would be a betrayal of patent and inviolate precepts.

* * *

Tentative Conclusions.—To what, now, do the foregoing and similar thoughts lead us, in so far as the proposed Basic Science Initiative is concerned:

The answer is: To nothing more than this, namely, that:

(a) A Basic Science Initiative will be placed on the California Ballot non-retroactive for all practitioners of the healing-art now licensed, but applicable to applicants of the days to come; and

(b) The real struggle for the enactment into law in November, 1942, of this proposed initiative is now in the lap of the Medical Profession of California, and of the friends of that profession.

We, ourselves, placed it there. There it will remain, for better or for worse. If, at this time we each, and all of us, fail to do our respective parts, the end-result may be nothing else than the non-enactment of the initiative by the electorate, implying by that, not only disaster for the present, but also, for many years in the future.

True, these may be unpleasant thoughts. Better said, however, in advance, than afterward. It is important that every Doctor of Medicine in California, should fully appreciate his personal responsibility in the issues at stake.

* * *

Recapitulation.—To place the proposition bluntly, let us recapitulate:

(1) Since the year 1927, a Basic Science Law has been consistently advocated in California.

(2) Two trial ballots were submitted in the California Legislature, in an effort to learn the sources of possible opposition.

(3) The initiative law is the only method that would make such a measure applicable to existing healing-art groups already recognized by the State of California (so-called Regulars, Osteopaths, and Chiropractors.)

(4) The Basic Science Law sponsored by the California Medical Association, the State Dental Associations, and the Public Health League will be on the November, 1942, ballot.

(5) In spite of their high pressure methods, the effort to have a "Basic Subjects Law," as proposed by certain Chiropractic groups, died "a'borning."

* * *

Real Battle for a Basic Science Law is Still Ahead.—But, in spite of all the above:

The Real Battle is now about to start.

Let there be no doubt about that.

Keep in mind, those of you who were in the superoptimistic group at previous C.M.A. annual sessions, and told how easy it would be to secure 200,000 or more of valid names of voters, that after a very strenuous campaign, with many legal workers, a total of only 107,000 valid signatures were secured from doctors, dentists and their friends.* The other signatures, between that number and up and beyond the 212,117 needed, were obtained through commercial solicitors, for cash, and on which the regulation fee of ten cents plus was paid. The money so expended ran into some thousands of dollars. This is stated simply to emphasize how, on matters concerned with public health, i.e., on non-personal interests, we are willing so often to let the other fellow do the work; and, sad to relate, if failure results, we who have been derelict ourselves, are prone to cast reflections, not on ourselves, but more often on the "Other Fellow," or, easier still, on the "Officers of the Association," who supposedly did not do their part. Such is human nature!

In placing the matter so frankly, and in form, perhaps, almost to arouse antagonism, our sole motive is to attract sufficient attention to make members of the California Medical Profession—and through them, their friends and supporters—realize that the Real Fight for the enactment of this Basic Science Initiative is still ahead of us.

* * *

Chances of Initiatives in a State Election.—A brochure, "The Initiative and Referendum in California," from the John R. Haynes Foundation of Los Angeles (it was the late John R. Haynes, M. D., of Los Angeles who was the sponsor of the California Initiative), states:

> . . . From the adoption of Direct Legislation in California in 1912 until 1938, ninety-nine initiative propositions have been submitted to the electorate, of which forty-one were statutes. . . . Of the initiatives voted on, twelve statutes have been approved by the electorate. . . .

The above statement is worthy of thought because it indicates that it is more than four to one that a "statute initiative" (and that is the class to which the Basic Science Initiative belongs) will be voted down!

* Of the 107,000 signatures so secured, 70,000 were valid.

Now these were all patent facts before we engaged upon this struggle to protect the citizens from incompetent healing-art practitioners. What do these facts imply?

* * *

The Task Ahead: What Shall the Story be? Victory or Defeat? And Upon Whom Must the Responsibility Rest?—Is it not plainly evident, from what has been here presented, that the Basic Science Initiative, promoted and intended for the protection of the citizens of California, will be enacted only if the voters of California appreciate its beneficent purposes?

At the present time, the struggle is even more difficult, because with War psychology everywhere in evidence, it may be said there is only transient or casual interest in State and local politics. Meaning what? That, by-and-large, the voters will go into the booths in November next, and vote No rather than Yes, on initiatives, referendum and similar measures. These are the cold facts, based on the recorded analyses of initiative measures submitted since the year 1912. To ignore them, lays the groundwork for defeat. And then, what?

* * *

The Objective is Laudible. But Doctors of Medicine and Their Clients and Friends Have a Hard Fight Ahead.—The battle can be won and it will be won for the betterment of California's citizens, if every Doctor of Medicine will do his part and lend his fullest aid, through himself and his friends, to carry on, between now and November election day, a strenuous campaign of education of all voting citizens.

This means, the educational campaign must be carried on in good part by physicians; through direct conversations with their patients and friends, and contacts with service clubs, and other groups with which they have affiliations. It envisages coöperation by members of the State Woman's Auxiliary and its component county groups, by Doctors of Dentistry, Pharmacists, and other learned professions.

* * *

The Story to be Told.—The story to be told is so simple, so honest, and so fundamental, that, in essence, it is as follows:

The State of California should license only those practitioners of the healing-art—no matter to what school belonging—who have given evidence through examination, that they possess sufficient fundamental education to indicate that health and lives of citizens may be safely placed in their care, and that they are, therefore, worthy as applicants for State Licensure.

And primarily; that is all a Basic Science Law is intended to promote. Surely, every citizen has an interest in that kind of protection for himself and for those whom he loves.

If we can get this basic message across, success will be ours. If we, as physicians, fail to educate our fellows concerning their own primary interests, and our own kindly desire to aid in their protection, we may go down to defeat. This in spite of all past effort and funds expended in sincere desire to place this law on the statute books of California.

Doctor, you who read this, will you do your part?

ANNUAL SESSION OF AMERICAN MEDICAL ASSOCIATION: A.M.A. TO MEET IN SAN FRANCISCO IN 1943

Some High-Lights of Recent A.M.A. Session.—The recent annual session of the American Medical Association, held in Atlantic City on June 8-12, was characterized by interest and enthusiasm, so much in evidence at this year's convention of the California Medical Association held at Del Monte, on May 3-6, last. Registrations of A.M.A. members in eighteen scientific sections totaled 8328, some 180 physicians from California being in attendance.

The Section meetings were interesting, but special mention must be made of the Scientific Exhibits which, more and more, are taking on a dominating place at the annual meetings of the National Association. The great interest of physicians in the newer researches and work, as given in these exhibits, was evidenced by the unending and attentive groups which crowded practically all the booths. Certainly, this type of post-graduate work is having much appeal to that increasing number of physicians who wish to contact and exchange views with colleagues whose work is not only thought-stimulating, but valuable in practice.

In this connection, the hope is expressed that members of the California profession will lend fuller coöperation in building up the scientific exhibits of our own State Association. Praise should be given, also, to the medical and surgical films which were presented in Atlantic City. The rooms allocated for these were constantly crowded.

* * *

San Francisco, as Meeting Place, Was Decided in 1940.—New York was selected as the place for A.M.A. session, to be held in 1945, three years hence; just, as in 1940, the A.M.A. House of Delegates decided that San Francisco should be the place of meeting for 1943, next year's session.

For a brief period, by the underground, it was rumored about that hotel and commercial interests of one or two mid-west cities intended to stampede this year's House of Delegates into changing the place of meeting from San Francisco. The California delegates promptly let the word go out that such an action was not within the power of this year's House; and the movement, while not absolutely quashed, found no spokesman who dared give expression to the plan

at any of the House meetings. In case of a War emergency, necessitating a change in meeting place, the authority for such action is vested, by the A.M.A. constitution, in the Board of Trustees.

* * *

San Francisco a Logical Place for an A.M.A. Session.—What War will bring forth, is difficult to forecast; but surely, there is no need to incite a fear-morale that would make physicians reluctant to visit the West Coast. The citizens of San Francisco, Los Angeles, Portland, Seattle, and other coast communities are proceeding with their daily routine and living, even though, perhaps, they may be somewhat more alert to the Country's military needs, than are those who are resident in some other regions.

San Francisco is one of the few cities in the United States capable of providing an annual session of the American Medical Association with every desired comfort and convenience. It has ample hotel accommodations, all centrally placed in the heart of the city, and in close proximity to the Civic Auditorium, with its spacious halls for section meetings, exhibits and films. Taxi service is excellent. The Twin Peaks and other hills cut off the heart of the city from direct contact to the Pacific Ocean, so that dim-outs are practically in less evidence than in most of the cities facing the Atlantic Ocean. So short a time ago as February last, San Francisco was host to the successful convention of American School Superintendents, at which a registration of 12,174 was recorded.

It is agreed that good reasons may be put forward regarding the undesirability of joy and pleasure conventions of what are primarily social organizations, but those arguments do not apply to scientific groups such as the American and California Medical Associations, whose members, in these present days more than ever, need to acquaint themselves with new methods and responsibilities, particularly in the realm of War Medicine. There is nothing to indicate that military authorities have any desire to interfere with legitimate gatherings.

Concerning the February meeting of the American School Superintendents, extra-state commercial interests started antagonistic rumors, in the hope of causing a transfer of meeting place. The fact that more than 12,000 teachers registered for that meeting—conceded by those in attendance as one of its best on record—shows the fallaciousness of such propaganda. In similar manner, prior to the recent C.M.A. meeting at Del Monte, stories kept going out up to the end of April, that there would be "No C.M.A. session in May of this year." The attendance of 1724 persons at that meeting, and the almost universal verdict that it has been one of our best conventions, is further testimony on why a most successful meeting of the A.M.A. can be held in San Francisco.

* * *

Cordial Welcome is Extended.—Next year's session of the American Medical Association in San Francisco will be enthusiastically supported by the local hosts, the San Francisco County Medical Society and the California Medical Association, and every effort will be made to promote a convention, that both intra- and out-of-state members will long remember; both for the value of its scientific work and the joy of foregathering in San Francisco, which is one of the half dozen American municipalities with historical background and picturesque surroundings, permitting it to stand in a class of its own. These thoughts are presented, therefore, to invite colleagues, in other States of the Union, to arrange their plans to join with Californians in making the 1943 session of the American Medical Association one of the best on record.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 60.

EDITORIAL COMMENT†

GOOD PRACTICE VS. MALPRACTICE

The incidence of malpractice claims is higher in California than elsewhere in the United States. Particularly is this true of the metropolitan centers, where the condition is both vicious and alarming. Because of the many claims and suits, physicians are suffering loss of prestige and great loss of time; moreover, they are being subjected to an increasingly heavy financial burden. Something must be done to meet this problem.

Theoretically, a doctor should be able to avoid accusations of malpractice if he cares for every patient with meticulous attention to the requirements of good medical practice. Actually, as the most unprejudiced analysis will disclose, the great majority of malpractice claims made, and suits brought, are without meritorious foundation. It is essential, therefore, that for his own protection the physician should endeavor, in so far as possible, to be in a position to prove that he has cared for every patient with the requisite degree of skill and care, in accordance with the standard imposed by the law.

Good medical practice is in itself not enough: the physician must be able to show proof of what he has done. California physicians must come to realize the seriousness of the malpractice problem and must determine to ameliorate the situation.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

When and if this awareness and determination can be achieved, the present ratio of ten or more cases in certain California counties to one case in counties of comparable population in some other sections of the country will change very markedly.

At the present time it may be wise to note that a physician who enters the military service, and leaves his civilian practice to be carried on by partners or by employees, is liable for their negligence or malpractice just as though he were still at home. In this connection the following case is illuminating and augurial: A partnership was held to exist in Runo vs. Rothschild (Michigan),[1] wherein a physician, while in the service of the United States Army, agreed to permit his assistant to continue the occupation of his offices and laboratory, and to practice for the plaintiff's patients, the income derived from such practice to be used to pay all expenses, and the balance to be shared equally.

It should also be remembered that the physician's liability as regards malpractice is not changed when he is treating military personnel as a medical officer of the armed forces. The Judge Advocate General of the Army has held that members of the Army are entitled to the same civil rights of action between one another with reference to suits for malpractice or negligence as they would have in civil life.[2]

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POTENTIAL DANGERS OF KEROSENE, GASOLINE, AND SIMILAR SOLVENTS FOR HANDLING BLISTER GASES ON THE SKIN

The common blister gases, such as mustard gas and lewisite, are soluble in kerosene, gasoline, acetone, carbon tetrachloride, and other similar fat solvents. During World War I, it was naturally assumed that such solvents would be useful in removing splashes of liquid blister gases from the skin. No data have appeared to support this idea. Nevertheless, the recommendation for the use of these fat solvents persisted, and has been taken over in current advice to civilians with respect to removing liquid splashes of blister gases from the skin.

It should be remembered that kerosene, gasoline, and acetone may be absorbed by the skin, and like carbon tetrachloride, are themselves skin irritants. They are also solvents of low viscosity and tend to spread easily. There is thus every liklihood that the use of these solvents would not satisfactorily remove a blister gas from the skin, but would on the contrary spread it over the skin, and produce a more serious injury than if they were not used.

Direct experimentation supports this view. In the chemistry laboratories of the University of California, Professor T. D. Stewart has studied mustard gas burns on the skins of many score of students. In our laboratory we have made similar studies on animals and human skins. Uniformly we have found that simple detergent solutions such as those produced by soap and water are more effective if used promptly in removing blister gases from the skin than are such solvents as kerosene, gasoline, acetone or carbon tetrachloride. The latter frequently produced more extensive and severe burns in connection with blister gases on the skin, than are noted in untreated controls.

It would seem wise, therefore, to revise recommendations t ocivilians for handling potential was gas injuries by removing all reference to such solvents as kerosene and gasoline. Revisions have already been made in national recommendations with respect to the use of hydrogen peroxide for treating was gas injury to the eyes, particularly if lewisite is suspected. The original recommendations were to wash the eyes with a 3 per cent solution of hydrogen peroxide. Direct experimentation by Professors P. J. Hanzlik and M. E. Tainter at Stanford Medical School and by ourselves showed the potential danger to the eye of such a relatively strong oxidizing solution. This was confirmed by Chemical Warfare Service workers, and the recommendation was revised to a 0.5 per cent solution. Later, this was abondoned entirely, and the suggestion of the San Francisco Committee on the Medical Aspects of War Gases was adopted, namely, to wash the eyes with a 2 per cent solution of sodium bicarbonate.

The simplest and most effective advice for civilian protection against was gases seems to be: (1) obey air-raid rules, taking refuge in an air-raid shelter or blackout room with doors and windows shut; (2) if the shelter is broken open by bombing, and war gases are suspected by odor, fog, or smarting or stinging in eyes, nose, throat, or by sneezing or coughing, tie a cloth soaked in soda solution over the nose and mouth to breathe through, shut one eye, squint through the other, and lie down with head in arms; (3) if eyes, nose, or throat are irritated, wash out with solution of teaspoon of baking soda in glass of water; (4) if it is suspected that splashes of liquid are on clothes or skin, throw clothes out of window, lather skin copiously with soap and wash thoroughly, or blot the contaminated skin with a cloth wet with a 3 to 5 per cent buffered kitchen bleach solution of sodium hypochlorite, such as 'Clorox," "Sani-Clor," or "Purex," and then fellow with soap and water. If subsequent injury results, first-aid and medical management is symptomatic.

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ORIGINAL ARTICLES

Scientific and General

BURN WOUNDS: THEIR TREATMENT*

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THE war, which has broken loose over most of the world, carries a high percentage of burn casualties, striking the civilian population as well as the armed forces. Many of us will be called upon to treat these wounds, and it is essential that we have a clear conception of the basic principles on which the treatment of burns is founded. Burns have become a major medical problem.

THE BURN WOUND AS A CONTAMINATED WOUND

Before taking up in detail the treatment we are using at present, I would like, briefly, to review the contributions made to this subject during the past fifteen years, which have given us our conception of the burn wound. This work was first stimulated by Davidson[1] in 1925, when he introduced the closed treatment of the burn wound by the use of tannic acid. After a superficial cleansing and debridement, tannic acid solution was applied to the burned surfaces, for twelve to twenty-four hours, until they were tanned to a mahogany brown or black. The patient was then kept dry under a warm cradle.

This method of treatment taught us two important facts. From the successful cases having uneventful recoveries, we learned of the many advantages of the closed, or dry method of treatment. The lack of pain, fever, dehydration, and emaciation were a welcomed contrast to the picture of burns we had known heretofore.

From the large percentage of cases in which infection developed, we learned that, except for the period of initial shock, infection was practically the only difference between success or failure.

A few years later, Vilray Blair[2] expressed the opinion that burns were all infected wounds after the first twenty-four hours, and should not be closed. He recommended the use of hypertonic immersion baths and compresses. We found his method technically difficult. Its disadvantages made it impractical for adoption as a standard method of treatment.

Aldrich,[3] in 1931, after having taken cultures from burn wounds and finding them 100 per cent positive after the first twelve hours, endeavored to find an antiseptic that would prevent infection, and at the same time seal the wound. In 1933, he published his results, and recommended gentian violet as possessing these qualities.

In 1933, at the Alameda County hospital,[4] because of the frequency of infection with both tannic acid and gentian violet, and after having obtained positive cultures from 90 per cent of burn wounds immediately upon entry to the emergency ward, we began the aseptic preparation of the burn wound before any local application was made. All cases were taken to surgery. Under N_2O anesthesia, the burn wound was thoroughly cleansed with soap and water, followed by alcohol and ether. After cleansing tannic acid compresses were applied, and the patient returned to bed between sterile sheets under a warm cradle. Every effort was made to prevent wound contamination during the after-care.

Our results, which demonstrated a marked improvement over methods formerly used, were published in CALIFORINA AND WESTERN MEDICINE in 1934.[4] We stressed, in this article, apparently for the first time, the burn as a contaminated wound, and as such, should never be closed without preliminary cleansing. We emphasized the application of the principles of surgery to the burn wound in the same manner we would apply them to any other type of wound.

The use of silver nitrate in conjunction with tannic acid was introduced by Bettman[5] in 1937. His claims, that infection was lessened and that coagulum formed more rapidly and was more pliable, have been substantiated. We have found silver nitrate useful with gentian violet, as well as with tannic acid, and have obtained equally good results from the so-called Triple Tan, when all three are used.[6, 7]

Triple Dye, a mixture of 2 per cent gentian violet, 1½ per cent brilliant green, and .1 per cent acriflavine, was suggested by Aldrich in 1937.[8] It was the result of a long series of experiments in search of a bacteriacide which would possess the advantages of gentian violet and, in addition, destroy gram negative bacteria. Triple Dye has become very popular in the past few years, both in Great Britain and this country. Rear Admiral Wakeley, of the British Navy[9, 10] states that it is more widely used in England, during the present war, than any other burn application. Inasmuch as it is a closed treatment, the careful preliminary preparation of the wound is implied. This solution is stable for about one week, and, because it is sensitive to light, should be kept in an amber bottle.

Within the past two years, a method of treating burns has been recommended by the plastic surgeon utilizing the principles used in skin grafting.[11, 12] After a thorough aseptic cleansing, vaseline gauze, or fine mesh gauze, moistened in saline is applied. This is covered by voluminous fluffed gauze dressings held in place by a pressure bandage. The dressing is not disturbed for eight to fourteen days. This procedure is a closed treatment, depending for its success upon the meticulous preliminary cleansing. In a method for general use, we feel it is safer to choose one that permits the wound to be inspected daily for the earliest signs of infection.

One of the most spectacular contributions to

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medicine in the past few years has been the introduction of the sulfonamides. Robson and Wallace, in 1941,[13] reported favorably on the use of sulfanilamide paste on war burns. The same year Pickrell[14] reported one hundred cases treated successfully with 3 per cent sulfadiazine in 8 per cent triathanolamine. He recommended the immediate spraying of the burn with this solution, to relieve pain and limit bacterial growth. As soon as possible, thereafter, the wound is aseptically cleansed and debrided, after which it is sprayed at regular intervals for several days until a firm coating, or eschar, covers the wound. During the past year there have been numerous reports[15] of the successful use of sulfanilamide and sulfadiazine, but the high-blood level, which at times follows their local use in small burns, indicates there is danger of over-dosage, if applied indiscriminately.[16] Pickrell reports only one case as showing toxic effects of absorption. Their use should be encouraged in hospitals where their action, advantages, and disadvantages can be carefully recorded. It is quite likely that a sulfonamide compound will eventually prove a valuable contribution to burn therapy.

In 1941, Bunyan, of Oxford, described a waterproof enevelope which he devised especially for treatment of burns of the extremities, wherein the burn area is constantly irrigated with electrolytic Hypochlorite solution. We are not familiar with this type of treatment and cannot comment upon its merits.

Paraffin wax, which was popular as a burn treatment during the last war, later lost favor because of the frequency of infection. It has been again recommended for use in some of our naval hospitals. Our experience with paraffin wax on fresh burns has been highly unsatisfactory.

In the *New England Journal of Medicine,* of April 16, this year, Wells presents evidence, gained at autopsy and animal experimentation, that severe liver damage may be caused by the absorption of tannic acid. He states that the injury to the liver varies from a mild hepatitis to central necrosis, depending directly upon the amount absorbed.[17]

It may be confusing, when we review the current literature on burns, to find capable surgeons, each recommending a different type of burn application and obtaining successful results. The treatments most in favor include triple dye, tannic acid and silver nitrate, gentian violet—with or without silver nitrate—gentian violet jelly, sulfanilamide, sulfadiazine, and pressure dressings applied over vaseline gauze or fine mesh gauze moistened in saline. From these apparently divergent views we find the key to the successful treatment of the burn wound. *The successful results are due to the careful preparation of the wound, and the alert, painstaking after-care, rather than the specific type of application.*

SHOCK

In the general management of the burn case, as in other forms of severe trauma, shock warrants our first consideration. The many contributions made to this subject, during recent years, have led to a marked improvement in treatment and to a reduction in mortality. Clinical and experimental evidence show that severe shock causes an increased permeability of the capillary walls, with a leakage of the fluid elements of the blood into the tissues. These consist primarily of plasma proteins and, in turn, water and salt. The results are a fluid imbalance, a concentration of blood in the vessels, lowered blood volume, a slowing up of the circulation, with a consequent anoxia of the tissues and organs of the body.[18] With a consciousness of the importance of fluids and fluid balance, a few simple tests are necessary to determine the requirements of the patient suffering from shock.[19] The determination of the plasma protein of the circulating blood, together with the clinical picture will, in most cases, suffice. Scudder states that the information most important is the trend toward, or away from normal, as judged by repeated tests rather than by a single set of determinations. There is now general agreement that plasma or serum transfusions, supported by an adequate amount of saline, are the best type of replacement therapy.

In mild cases, from 250 to 500 c.c. of plasma is usually sufficient. More severe cases may require from 500 to 1000 c.c., depending upon the clinical picture and plasma protein determination. In very extensive burns, as much as ten liters may be required over a period of days.

When the plasma proteins are low, glucose and saline solutions by themselves fail to aid the situation, and actually tend further to wash plasma proteins out of the circulation.[20] The latter are required to raise and maintain osmotic pressure which, in turn, keeps the water and salt in the vessels. From 3500 to 4000 c.c. of fluid intake is usually all that is required by the average patient to balance the insensible loss of water and urine. Moderate amounts of glucose and saline, in addition to plasma, may be necessary to balance this fluid loss, but the administration of large quantities of this solution alone, defeats the purpose for which it is given.

Some evidence has been presented to show that adrenal cortical hormone, when given in conjunction with plasma decreases the leakage of plasma proteins, thus lessening the amount of plasma it is necessary to transfuse.

The relief of pain with morphia, the maintenance of body heat, and the administration of oxygen are general measures to be used, according to the requirements of the patient.

FRESH BURNS

In fresh burns involving the larger body surfaces we prefer a closed or dry method of treatment. Intravenous therapy and general care are more easily administered, with a restful patient

free from pain and the necessity of painful dressings. At the present time, we are using triple dye for this purpose. Aside from its bacteriacidal action, it is inexpensive and easily applied. These factors are important in an emergency where time and equipment must be considered.

As soon after admission to the hospital as the condition of the patient will permit, the burn wound is quickly and thoroughly cleansed and debrided, using white bar soap, large cotton swabs, and an abundance of warm water. A solvent is used to remove grease. This operation if done quickly and gently, can usually be done under morphine analgesia. If deeper anesthesia is required, cyclo propane is used. When the wound is thoroughly cleansed, several coats of triple dye are applied with a spray, each coat being dried with a warm air dryer. The patient is then returned to bed between sterile sheets, under a warm cradle. In the after-care, every effort is made to prevent wound contamination.

INFECTED BURNS

When six or more hours have elapsed before a burn is treated, it should be considered as an infected wound. These burns, like the grossly infected, should not be closed with coagulants. The wounds are first gently cleansed and debrided. After cleansing, our treatment varies with the individual requirements of the case. The sulfonamide drugs, saline compresses, immersion baths, and dry warmth may be used as the occasion demands. Baths and compresses are usually alternated with periods of dry warmth, to prevent maceration of the tissues. Hexylresorcinol in mucilage Tragacanth has proved useful in some cases.

When triple dye is used to combat infection or to add to the patient's comfort, only a thin coating is applied, which can be easily removed in the bath or by moist compresses. When crusts tend to form, overlying pockets of infection, we use the saline immersion bath for one hour each day. There is no specific treatment for this type of burn.

REGIONAL BURNS

Burns of the hands, feet, face, and genito rectal regions deserve especial consideration. It is difficult to secure and maintain asepsis in these areas. Infection frequently occurs, carrying with it the risk of serious disability and disfigurement. We have not attempted any form of closed or dry treatment upon these areas for the past seven years.

Burns of the hands are frequent among war casualties, and one of the common causes of disability and invalidism from the service. These wounds are rendered aseptically clean, and every effort is made to keep them clean. Except for the meticulous cleansing and debridement, the treatment we are employing is similar to the treatment for infected burns.

Our usual routine consists in moist saline compresses applied for about twelve hours daily. This is most conveniently done at night. Every morning the dressings are gently floated off in a one-hour saline bath, in which flexion and extension of the fingers are encouraged. This is followed by dry warmth under a cradle until the compresses are reapplied. Hand burns grossly infected upon admission are dusted with sulfanilamide before applying compresses. As soon as the surfaces are healed, the delicate reddened skin is gently massaged several times each day with lanolin. Active and passive movements of the fingers are continued. Without this care, disability may be prolonged for several months.

Burns of the face are time-consuming and difficult. Infection usually occurs. After these wounds have been cleansed and debrided, they are dusted with sulfanilamide, and compresses are applied. In face burns, grossly infected, an 8 per cent solution of sulfanilamide is applied as a compress for several hours daily.

Crusts overlying pockets of infection, that tend to form about the face, head, and neck, may be softened with peroxide and removed by gentle cleansing with warm water and soap. Vaseline gauze or cod liver oil ointment is applied over bleeding points to prevent dressings from adhering. To add to the patient's comfort, these wounds are occasionally painted with a thin coat of triple dye, and left exposed during the day.

Burns of the feet and the genito rectal regions are treated as infected burns, with the alternate use of dry warmth and saline compresses. A thin application of triple dye may also be used. Immersion baths are used when the wounds are soiled and crusted.

We wish to emphasize the importance of early skin-grafting in all areas where the skin is destroyed. Early grafts relieve pain, minimize the fluid loss, shorten convalescence, and prevent scar tissue contractures and disabling deformities.

FIRST AID

In the first aid treatment of the burn wound a simple covering of sterile gauze is sufficient. The use of ointments, oils, and tannic acid preparations only add to wound contamination, to the problem of cleansing, and to subsequent danger of infection. A sulfonamide may be used when early cleansing is not feasible.

CONCLUSION

It is quite possible, with the renewal of interest in this subject, that the local treatment of the burn wound will undergo many changes before this paper is published.

Of the sulfonamides, only the first chapter has been written. With the large amount of experimental work in progress, it is more than likely that a sulfonamide compound not yet released may play an important part in the treatment of the burn wound, and supplant the local applications now in favor.

In our enthusiasm over new contributions as

they appear, we should not lose sight of the fact that the burn is a contaminated wound and its treatment a surgical problem. This implies a careful preliminary preparation of the wound and an equally important painstaking after-care.

The successful care of the patient who has suffered from severe burns is not easy. It takes time and hard work, but the author knows of no instance where your efforts will be as generously rewarded.

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THE PHYSICIAN AND THE NATIONAL NUTRITION PROGRAM*

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DISCOVERIES of and about vitamins initiated a great development in the science of nutrition, and the occurrence of the war is precipitating profound changes for the people in the practical application of this scientific information. It is the purpose of this presentation to discuss the latter phase of this matter, and to consider the place of the physician in the National Nutrition Program.

By way of introduction, one may well ask the question—whether there exists a national nutrition problem? Are all of the people in our country adequately nourished in terms of modern knowledge of nutrition? If not, how many are not well-nourished, in what ways do they fail to be adequately nourished, and what can be done to see to it that they become properly nourished? In the brief period allotted for this discussion it is not possible fully to answer these questions. To present evidence of the existence of a national nutrition problem, I should like to quote the conclusions of a subcommittee of distinguished nutritionists,[1] appointed by the Food and Nutrition Board of the National Research Council to evaluate existing evidence on the question of the prevalence of malnutrition in the United States. It is stated that: "The evidence at our disposal warrants the conclusion that dietary inadequacies and malnutrition of varying degrees are of frequent occurrence in the United States, and that the nutritional status of an appreciable part of the population can be distinctly improved. If the optimal nutrition is sought, not mere adequacy, then widespread improvement is possible."

THE NATIONAL NUTRITION PROGRAM

The immediate background, for the present National Nutrition Program, may be said to date from the spring of 1940. At that time a newly-appointed committee on Food and Nutrition of the National Research Council was requested by the Surgeons General of the Army and Navy, to give advice concerning the rations of men in the armed forces. It is no military secret that, until that time, the ration of Army and Navy personnel had been considered nutritionally in terms only of calorie and protein content. Now, with a large group of men coming into active duty under the Selective Service Act, it seemed wise to consider, in the feeding of them such things as vitamins and minerals, as well as calories and proteins, and the need for these various factors under a large variety of conditions. As a result of this activity, there was precipitated much interest in problems relating to the nutrition of all of the people. In turn, this led to initiation of the program for enriched flour and enriched bread, and calling of the National Nutrition Conference for Defense held in Washington in May, 1941, at the request of the President of the United States. There was also set up a Nutrition Advisory Committee to the Coördinator of Health, Welfare and Related Defense Activities (now the Office of Defense Health and Welfare Services), and subsequently a Division of Nutrition in the Office of Defense Health and Welfare Services, of which Mr. M. L. Wilson is the chairman.

The interest in nutrition stimulated by people in these groups was intense, and has lead to a National Nutrition Program which is given scientific guidance by the Food and Nutrition Board

* Chairman, San Francisco County Nutrition Council. Read at the general session of the California Medical Association, Del Monte, California, May 3-6, 1942.

of the National Research Council. Professors of home economics in the land-grant colleges in each state were designated as chairmen of state nutrition committees, and encouragement was given to the development of nutrition committees in each county in the United States, with representation thereon of physicians, dentists, nurses, home economists, dietitians, and public health officials, and laymen of action groups, such as the Parent-Teachers' Association, Red Cross and American Legion, of food manufacturers, retailers and distributors, and of numerous other agencies. In essence, the function of the county nutrition committees is (1) to coördinate and assist in nutrition programs of the state and county, as developed by permanent agencies in the community, and (2) to initiate and carry out projects for the attainment of better nutrition in the community. In other words, this phase of the campaign is largely an educational one, to see to it that every child and adult shall have information on the essentials of good nutrition in terms of foods which are available to them.

The causes of malnutrition are (1) economic difficulties in obtaining proper food, (2) lack of information as to what constitutes an adequate diet, and (3) the widespread availability and use of processed foods from which vitamins often have been partially removed or destroyed in manufacturing or processing. It has been stated that there are three ways in which the problem of malnutrition may be met on a large scale: (1) by educating people regarding an optimal diet, (2) by giving to each of us daily a vitamin pill or tablet, or (3) by restoring to foods vitamins and minerals removed from them in the process of manufacture or preparation—namely, by the so-called "enriching" of foods. Of these the first and the last are the only practicable and sound solutions economically and nutritionally. The matter of enrichment of foods is one to be taken up on a national scale, and is not the function of a state or county nutrition committee alone. However, local groups have, as their principal task, the matter of educating people as to what to eat to be well-nourished and healthy. This task may be accomplished in part by existing agencies whose activities are coördinated with those of county nutrition committees. These activities center in courses in nutrition, nutrition demonstrations, further extension and development of the school-lunch program, studies of food habits of different races and types of people, encouragement of proper advertising of foods, education of children in good nutrition, determination of methods to assist those in low income groups to be adequately nourished, stimulating the development of and maintaining a library of books, posters, pamphlets, movies and other informative material on nutrition for public use, and in numerous other fields.

THE RÔLE OF THE PHYSICIAN

What is to be the rôle of the physician in developing and furthering this National Nutrition Campaign? Is he to sit idly by, while others not trained in medicine but well versed in the science of nutrition and in methods of educating and selling, assume leadership in a campaign which deals so closely with the health of his patients and people in general? Can he nonchalantly ignore the ever-growing number of dietary quacks who new find in the national campaign a helpful stimulus to sell more and more of this or that favorite vitamin pill, syrup or "health food"? Indeed not! It is he who must provide a positive leadership in this national and local effort, to raise the standards of nutrition and, consequently, the health of the people of the United States.

How is it to be done? The answer is simple. As pointed out by Sebrell,[2] it depends on the development of a new point of view in preventive medicine—a point of view which already recognizes the importance of such things as vaccination against smallpox, immunization against diphtheria and sanitation of water and sewage, but still more is concerned with building the healthiest possible population with the greatest resistance to disease. A major part of such a program is that the population shall receive a diet adequate in all respects. In other words, the physician must begin to think more and more in terms of health than of disease, particularly as it applies to nutrition. Potentially, nutrition offers more to medicine—preventive and therapeutic alike—than has been offered by any branch of medicine, not excluding bacteriology, chemistry, surgery and chemotherapy, and offers it in a very simple and certainly pleasant way. (In this connection it is worthy of note that dietary deficiency diseases are an unusual group of diseases, in that they are almost completely preventable and, with the exception of a few extreme examples, almost completely amenable to cure.)

HOW PHYSICIANS MAY GIVE LEADERSHIP

May I make the following suggestions of ways in which physicians may give leadership in this campaign:

(1) *Be familiar with the nutrition standards set up by the Food and Nutrition Board of the National Research Council, and by the Council on Foods and Nutrition of the American Medical Association.* These standards have been very carefully considered and compiled, and, while they may subsequently require revision, stand at present as acceptable to the majority of experts in nutrition in this country. Familiarity with these standards simplifies greatly the practical application of the fundamentals of nutrition. In the application of these standards in terms of foods, particularly for those people with problems because of food habits, because of limitation of income and because of ignorance of food-values, great help can be obtained from dietitians, home economists and nutritionists trained in the practical application of this information. In time a physician will come to look upon the dietitian

working under his direction as an invaluable and time saving agent in filling a dietary prescription, just as he looks now to the pharmacist to fill a prescription for drugs in a manner which largely has replaced the dispensing of drugs by the physician.

(2) *Give leadership in the educational campaign by supporting, developing and guiding the local nutrition committee and campaign whenever and wherever possible, and by personally teaching whenever possible.* Most people naturally turn to physicians for guidance in matters pertaining to health, and this rôle of guidance and leadership must not be forsaken in the field of nutrition, because the physician is too busy caring for those who are sick. There are experts trained in many phases of nutrition, in economics of food and in the preparation and manufacture of them. From these experts the physician may get much helpful advice, but it is he who must assume the positive leadership in a matter dealing with health.

(3) *Encourage the use of foods rich in essential foodstuffs and especially enriched foods, and similarly discourage the promiscuous use of self and loosely administered preparations of vitamins and diets.* Much could be written of the great economic wastefulness of preparations of vitamins. In 1937 the American public spent approximately $100,000,000 for such preparations, and since that time many more hundreds of millions of dollars have been spent for these substances in various forms for therapeutic reasons, much of them self-prescribed and administered. Our thought of vitamins should be in terms of them as foods, and not drugs, and every effort should be made to satisfy the requirements of vitamins and minerals by adequate diet and not by medicinal preparations of them, the use of which largely should be restricted to the supplementing of restricted diets and to the treatment of disease.

(4) *Be prepared to supplement therapeutic diets, so that adequate standards of nutrition will be maintained.* The use of specialized diets for therapeutic purposes over long-continued periods of time is increasing rapidly. Many limited diets for treatment of diseases of the gastro-intestinal tract, such as peptic ulcer and chronic ulcerative colitis, of diseases of the heart and kidneys, of allergic conditions, and for purposes of weight reduction carry insufficient amounts of the "essential substances." Physicians have observed cases of pellagra, beri-beri and even scurvy brought on by the long continued use of limited diets, and unquestionably many patients have developed less severe degrees of malnutrition while following them. Frequently during pregnancy and lactation it is advisable to supplement the diet to maintain optimal nutrition for the mother and child. Many therapeutic diets need to be supplemented by vitamins and minerals in the form of natural foods sources, concentrates or synthetic preparations of them, preferably the first. For the successful instruction of the patient in the prescribed diet the services of a trained dietitian many be very helpful, if not invaluable.

(5) *Finally, in nutrition, think of the positive side of medicine, i.e., the attainment and preservation of good health, and not the negative side —the treatment of disease.* Someone has said, "Why ask the physician about health; he knows only about disease?"

If we successfully carry out this nutrition campaign and give it the adequate leadership of medicine we will have accomplished one of the greatest public health movements of all times, we will have continued our positive leadership in health, and we will have taken another definite step forward. And then, as Sebrell[2] has so well said, we may "Eagerly look forward to the days when our children and our children's children will be armed with the armor of robust health."

490 Post Street.

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GOVERNMENTAL AGENCIES AND MEDICAL PRACTICE*

HARTLEY F. PEART, ESQ.
San Francisco

THE report of the Legal Department is printed in the Pre-Convention Bulletin and I will not burden you with a repetition of any of the matters contained in it. I do, however, desire to call to your attention and briefly discuss a vital development in the field of government which has crept upon us in the past few years and which, if not properly understood, may engulf the profession. I refer to the mushroom-like growth of administrative agencies of the Federal government. In its approach to socialized medicine the profession has for years thought in terms of legislatures, votes, bills, initiatives, elections and all of the things that pertain to the legislative branch of the government.

The profession has been facing the legislative front and thinking in terms of legislative action. It has been prepared to defend itself against legislative attack and it has successfully done so. But, while the profession is facing the legislative front and thinking in terms of legislation, an entirely different attack is being carefully planned and executed by a different branch of government, namely: the executive or administrative branch. Unless the profession

* Supplemental report made to House of Delegates of California Medical Association at the Seventy-first Annual Session, Del Monte, California, May 3, 1942. Reference is made thereto in minutes of H. of D. in this issue. Prior report appeared in Pre-Convention Bulletin, April, 1942, C. and W. M., on page 210.)

abruptly wheels a part of its forces around and faces the administrative threat also, it may suddenly find itself defeated from the rear while it has had its guns trained on the front.

You are all aware of the fact that boards, bureaus, agencies and offices have sprung up in Washington in great number in recent years, but are you aware of just how many there are and how extensive are the powers that they wield. I have here a recent list of Federal government agencies other than the ten executive departments which are headed by Cabinet officers and various independent commissions and boards. I will read the list to you:

A List of Governmental Agencies

Advisory Commission to Council of National Defense
Agricultural Conservation and Adjustment Administration
Agricultural Marketing Administration
Agricultural Marketing Service
Agricultural Research Administration
Army Specialist Corps
Board of Civilian Protection
Board of Economic Operations
Board of Economic Warfare
Bureau of Industry Advisory Committees
Bureau of Research and Statistics
Commodity Exchange Administration
Coördinator of Government Films
Coördinator of Information
Council of National Defense
Defense Communications Board
Defense Contract Service
Defense Homes Corporation
Defense Labor Advisory Committees
Defense Plant Corporation
Defense Resources Committee
Defense Savings Staff
Defense Supplies Corporation
Division of Contract Distribution
Division of Defense Aid Reports
Division of Defense Housing Coördination
Division of Press Intelligence
Economic Defense Board
Electric Home and Farm Authority
Export-Import Bank of Washington
Family Security Committee
Farm Credit Administration
Farm Security Administration
Federal Bureau of Investigation
Federal Home Loan Bank Administration
Federal Public Housing Authority
Food and Drug Administration
Government Printing Office
Joint Mexican-United States Defense Commission
Metals Reserve Company
National Defense Mediation Board
National Defense Research Committee
National Housing Agency
National Patent Planning Commission
National War Labor Board
National Youth Administration
Office for Coördination of National Defense Purchases
Office for Emergency Management
Office for Agricultural Defense Relations
Office of Censorship
Office of Civilian Defense
Office of Coördinator of Inter-American Affairs
Office of Defense Health and Welfare Services
Office of Defense Transportation
Office of Export Control
Office of Facts and Figures
Office of Government Reports
Office of Lend-Lease Administration
Office of Merchant Ship Control
Office of Petroleum Coördinator for National Defense
Office of Price Administration
Office of Price Administration and Civilian Supply
Office of Production Management
Office of Scientific Research and Development
Permanent Joint Board on Defense
Plant Site Board
Priorities Board
Rubber Reserve Company
Solid Fuels Coördinator for National Defense.
Supply Priorities and Allocations Board
United States Information Service
War Production Board
War Relocation Authority
War Shipping Board
Work Projects Administration

All of these agencies are responsible only to the President. They possess tremendous powers and some of them *can* and *will*, and *have* entered the field of medicine in a tremendous degree. How much further they will go depends to a great extent upon the medical profession.

Let us consider briefly those agencies which have so far affected medical practice.

1. FEDERAL SECURITY ADMINISTRATION

We now approach civilian agencies. Federal Security Administration, created by Presidential proclamation some time ago, is the executive agency having control over the United States Public Health Service, the Social Security Board, the National Youth Administration and many other bureaus and offices. Federal control over medicine is *definitely* within its plans and powers. It is achieving that goal quietly and through administrative action and without any reference to the legislative branch of government. Let us consider specific examples:

(a) Social Security Board:

This agency now controls unemployment benefits and old age benefits throughout the country. It has some jurisdiction over health services, as yet very limited, but the Board itself is constantly endeavoring to enlarge its power over medical care and in its recent annual reports has definitely demanded that a national program of compulsory medical care be included in its functions. It is still in the planning stage but don't fail to realize that all bureaucratic agencies constantly strive to extend their power and that the natural direction for the Social Security Board to extend is in the field of governmental medicine.

(b) United States Public Health Service:

The war has caused the concentration of large civilian groups in new housing areas. Medical care in these areas has not been overlooked by the government. On July 1, 1941, Congress appropriated for "emergency health and sanitation

ADVANTAGES

The advantages of the apparatus are many. Grafts, four and one-half inches by eight inches, can be taken at any desired uniform thickness, calibrated to one one-thousandth of an inch. Of special value is the ability to take grafts from any uneven surface, as the chest, abdomen or back, greatly enlarging the choice of donor areas.

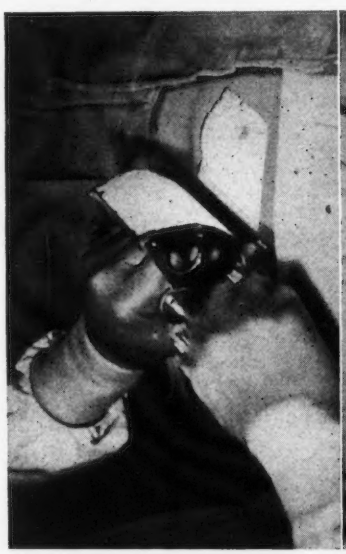

Fig. 1.—Skin graft adherent to drum. Also shows how drum is rolled while cutting.

Fig. 2.—Skin-graft being placed over burn. Note even texture of graft.

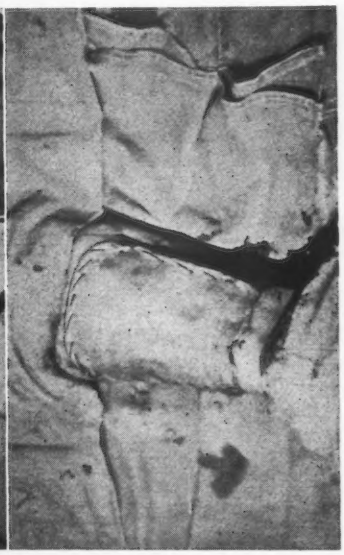

Fig. 3.—Graft sutured into position on leg.

An analysis of types of skin grafts with their advantages and disadvantages is pertinent. The Thiersch graft, the split-skin graft, the deep intermediate graft, and the full thickness graft represent the types. The Thiersch graft (.008 to .010 of an inch in thickness) covers raw areas with a high percentage of success. However, there is a great tendency for it to contract and ridge, and it offers little actual protection against trauma. The split-skin graft of Blair and Brown, with a thickness of .012 to .020 of an inch, consists not only of the epithelium but of a varying part of the corium. It is cut, freehand, with a large knife and varies considerably in thickness. To cut grafts of any size requires expertness of some degree. The grafts have a high percentage of take, and partake of some of the characteristics of full thickness skin, tend to contract less than the Thiersch type, but still do not protect as efficiently as the thicker type, nor do they match well with surrounding skin.

PADGETT GRAFT

The deep intermediate graft of Padgett, cut with his Dermatome, measures .022 to .030 of an inch, relatively seventy-five per cent of the full thickness of the skin. In appearance and protection value it approaches closely to full thickness skin.

Full thickness skin measures .032 to .045 of an inch and is ideal as a covering. However, the percentage of take is so variable, and the difficulty of management so great, that this type has only a very limited application. The donor area must be closed surgically, while that of the deep intermediate graft heals spontaneously within about two weeks.

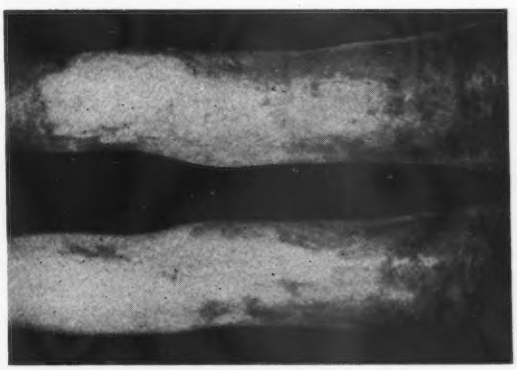

Fig. 4.—Healed burns of both legs. Large individual grafts are readily discernable, nine weeks after grafting.

The Padgett Dermatone consists of a drum with a movable knife fixed at a definite distance from the drum. This distance can be varied at will with calibrated set screws. Rubber cement is applied both to the donor area and the drum. The drum is set on the skin, then slightly rotated to raise the skin a little above the surrounding area, and the knife in its carriage is moved back and forth. A full drum can be taken, or, by simply lifting the drum, the graft can be cut off at any point.

Since the split graft or the deep intermediate

activities" in private industrial plants engaged in defense work and in areas adjoining such plants or government plants the sum of $1,235,000.00. A few months later another $2,000,000.00 was added to this appropriation. Both of these appropriations specified that the Public Health Service was to work in conjunction with and under state and local authorities. However, on February 21, 1942, another appropriation of $1,295,000.00 was made with the express provision that state and local authorities were to have no control whatever. The foregoing appropriations, while not large, are in addition to the regular Public Health Service funds for its normal activities. There is reason to believe that further appropriations will be made if the Public Health Service so desires. With the strings removed, Public Health Service can spend the money as it pleases. It doesn't take much imagination to visualize clinics staffed by government employed physicians in many "defense" areas.

We are not discussing here the necessity of proper medical care and service in housing and defense areas, but our view is that the profession itself can best furnish such care and service, without the establishment of employed staffs of government physicians.

(c) National Youth Administration:

This is a relatively minor matter but, just for your information, the National Youth Administration has statutory power to provide "emergency hospital and medical care" for persons employed by it on public projects.

2. NATIONAL HOUSING AUTHORITY

This agency was recently created by executive order and has control over all of the various Federal housing projects, including F.H.A., H.O.L.C., U. S. Housing Authority, Federal Works Agency, Defense Housing Corporation, W.P.A. and Division of Defense Housing Coordination. So far, only one of its divisions has entered the field of medicine, namely: the Federal Housing Agency.

(a) Federal Housing Agency:

In 1941 (42 U.S. Code, Secs. 1531-1534) Congress gave the Federal Housing Agency power over community facilities in defense public works. Community facilities were defined to include schools, sanitation, recreation and "hospitals and other places for the care of the sick." The law contained a provision that any hospital built through the Federal Housing Agency must not be under the control of the United States or any agency thereof as to operation. However, in actual practice, the agency has used its power to try to force local communities to extend county hospital care to full pay patients in return for construction grants. In other words, the Bureau is using the basic law as a means of forcing socialized medicine wherever it can. A total of $300,000,000.00 has been appropriated to date for defense public works community facilities. The next appropriation may eliminate the restriction against government ownership, just as the last Public Health Service appropriation eliminated the state and local authorities. If this is done, we will have a large government bureau nicely entrenched in all housing areas.

3. FARM SECURITY ADMINISTRATION

This agency, which is in the Department of Agriculture, is authorized by Congress to make government loans for "rural rehabilitation." In the fiscal year 1941-1942, $64,000,000.00 was appropriated to this agency for such purpose. Under its authority the F.S.A. can and does make loans that are earmarked for the express purpose of paying the cost of medical care. As it controls the purse strings it likewise controls the method under which medical care is rendered its borrowers.

4. OFFICE OF DEFENSE HEALTH AND WELFARE SERVICE

This is a so-called planning agency. It may be said to be the brain. With unlimited funds and a large personnel, it is busy figuring ways and means to accomplish whatever it wants to accomplish. Whatever plan it may evolve, you may be certain that it will place Washington in the driver's seat.

The foregoing are not all of the government agencies concerned with medicine, by any means. I have just picked a few examples. It must be understood that it is inherent in the nature of administrative bureaus to reach out for more and more control over more and more things. Furthermore, as bureaus, become entrenched legislators become afraid to move against them. Political employees in bureaus are the backbone of political parties and, hence, wield a tremendous power over the elected legislator.

Should not the profession give ever increasing study, thought and action to the end that, in the present war emergency and to meet peace time administrative encroachment, it can continue to furnish medical care upon a proper basis?

111 Sutter.

GRAFTING OF SKIN: ADVANTAGES OF THE PADGETT DERMATOME*

GEORGE WARREN PIERCE, M. D.
San Francisco

THIS paper is presented as an appreciation of the value of the Padgett Dermatome in the cutting of skin grafts; for this machine, designed by Earl C. Padgett, M. D., of Kansas City, Missouri, and introduced in 1938, constitutes the greatest contribution in many decades to the technique of skin grafting.

* Read before the Section on Industrial Medicine and Surgery, at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

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GEORGE H. KRESS, M. D., *Editor,* "California and Western Medicine"

* * *

FOREWORD: AN EXPRESSION OF APPRECIATION

The Tuberculosis Associations are deeply appreciative of the courtesy extended by the California Medical Association in making it possible to present to the readers of CALIFORNIA AND WESTERN MEDICINE the papers read before the 1942 annual meeting of the California Tuberculosis Association and the California Trudeau Society. It is hoped that this presentation will be of value to the physicians of the State.

The Tuberculosis Associations of California are anxious to coöperate at all times in giving whatever service is possible to the medical profession, to the end that our community health may be brought to its highest level.

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INDEX — TUBERCULOSIS SUPPLEMENT
Pages 19 to 58 inclusive

type are selected for grafting almost all raw areas, and since both can be cut with this machine, it has become indispensable to the reconstruction surgeon. After nearly two years' experience with the Padgett Dermatome, the author is enthusiastic about its merits and urges that its use be adopted widely.

The illustrations are of the apparatus in use and some of the author's cases showing the grafts.

490 Post Street.

CLINICAL NOTES AND CASE REPORTS

CONGENITAL ABSENCE OF THE PECTORALIS MAJOR*

CLIFFORD V. MASON, M. D.
San Leandro
AND
LOUIS J. RUSCHIN, M. D.
San Leandro

PARTIAL absence of the pectoral muscles is not infrequent.[1] Bing[2] estimated that they comprise 28 per cent of cases of congenital absence of muscles. However, Jones[3] believes this figure is too high, maintaining that many congenital absences are not as easily detected as the pectoral group.

Complete absence of the pectoralis major is rare. The usual lesion is absence of the sternocostal portion, with or without absence of the pectoralis minor. The well-developed, curved, anterior axillary fold is absent in these patients, and is only slightly compensated by hypertrophy of any remaining muscle strands. (See figure.) Absence of both major and minor have been reported.[3, 4, 5] Only one case of bilateral absence has been reported.[6]

Associated congenital anomalies of the homolateral hemithorax and upper extremity are quite common. Rib and costal cartilage defects,[7] breast defects, (see figure) syndactylism,[1, 8, 9, 10] shortening of the upper extremity,[7] brachydactylism,[7] absence of external abdominal oblique,[10] partial absence of the serratus anterior,[11] latissimus dorsi,[11] and intercostals[11] all have been reported.

Of the several theories advanced as to the etiology of pectoral defects, the most quoted is that of Lewis.[12] He found that in the 9 mm. embryo the pectoral muscle mass is largely above the first rib. In the 11 mm. embryo it extends lower, but it is still undifferentiated into its component parts, and is not attached to the ribs or humerus. In the 16 mm. embryo, the clavicular portion is split off and the remainder then divides into the sternal portion and the pectoralis minor. Perhaps the failure of the primitive mass to attach itself to the ribs and sternum might allow its not becoming differentiated into its normal component parts. This coincides with the known fact that the defects are usually in the caudal portion.

REPORT OF CASE

This patient is a 24-year old Japanese male, who was seen in the Lung Clinic of the Fairmont Hospital, in San Leandro, because of tuberculosis contact history. He was asymptomatic. Past history and functional inquiry are entirely negative. Family history, according to the patient, reveals no known congenital defects. Physical findings are entirely negative, except for the absence of the caudal portion of the left pectoralis major, and the left mammary gland. No functional impairment is detected clinically. Fluoroscopy and x-ray films reveal a normal bony thoracic cage. Heart and aorta are within normal limits. The lung fields are entirely clear. From the x-ray alone may be gained the impression of a previous left radical mastectomy.

Fairmont Hospital, San Leandro.

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INTRAVENOUS ANESTHESIA: A PRACTICAL METHOD FOR ITS ADMINISTRATION

JOHN H. GIFFORD, M. D.
Los Angeles

MOST anesthetists have developed a technique of their own for the administration of intravenous anesthesia, so that their hands are partially freed. When intravenous anesthesia first became popular, its administration was considered to be a two-man job; one to administer the anesthetic and the other to support the patient's chin and administer oxygen when necessary. Its administration can be simplified by the intermittent injection of the drug directly into the rubber tube of an intravenous infusion, but the routine use of this method is not justified because of its cost. Several ingenious mechanical devices have been developed to simplify the administration of intravenous anesthetic, but none of these are on the open market.

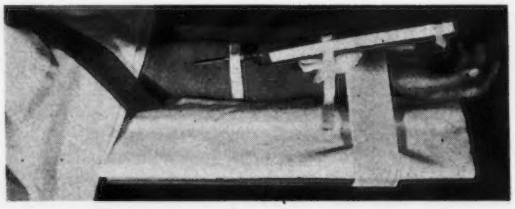

Fig. 1.—Showing application of the method.

(Continued on Page 59)

* From the Fairmont Hospital, San Leandro.

ORIGINAL ARTICLES

EVIDENCES OF TUBERCULOUS INFECTION IN PEOPLE DYING OF OTHER CAUSES THAN TUBERCULOSIS *

HENRY C. SWEANY, M. D.
Chicago

THE length of time of survival of the tubercle bacillus in the human body, a debatable problem since the work of Naegeli and Von Behring, respectively, resulted in a controversy near the beginning of the century. There was no question about Naegeli's observations, which have been supported by Orth, Beitzke, Opie, Schurmann and others regarding the presence of calcified lesions in practically all lungs of people dying of other conditions than tuberculosis. Whether they were "healed," as many thought, or how many contained living bacilli, were two phases of the problem that were not soon solved. But as time passed the infection rate for most countries gradually decreased, due largely to preventive measures. As a result, the number of such calcified lesions has decreased until in many districts today no more than half of the lungs contain them.

Von Behring's theory regarding the prolonged endogenous progession from childhood to adult life, however, was not so certain. The theory of bovine origin was surely not borne out in any more than a small percentage of cases, but Von Behring's ideas could not be treated lightly. As with so many problems in medicine there was much truth in his contention; the difficulty was apparently due to an incomplete knowledge of all conditions. Doubtless Von Behring actually saw some childhood infections ripen into disease in adult life; but the life time span of the disease is not the common type of endogenous progression. The span of disease rarely extends from childhood to adult life; often extends from childhood to puberty, or from puberty to college age. Many times, particularly in Naegeli's time, there was complete healing in childhood and reinfection in adult life.

The solution of the problems arising out of the apparent paradox was sought by every available means. The first efforts were devoted to seeing how many old lesions described by Naegeli contained bacilli. By inoculating the material into animals, Rabinowitch reported finding living bacilli in nearly half the calcified lesions and in about two-thirds of soft or chalky lesions. Loomis, Schmitz, Kurlow, Wegelin, and Lubarsch obtained comparable results. Opie and Anderson, however, reported positives in only about 30 per cent of all cases. They made pertinent observations also, overlooked by their predecessors, that most soft apical lesions contained tubercle bacilli, but rarely did they find the bacilli in focal calcified lesions elsewhere unless the apical lesions also contained them. To support these findings they reported 45 per cent positive results in lung tissue away from all focal tubercles, apparently bearing out the contention of Theodore Smith, Weichselbaum and Bergel that bacilli can live for long intervals in the lungs without causing any tissue reaction. Herbitz, McConkey, MacFadyen, Loomis, Pizzoni, Spengler, Straus, Wang and others reported similar observations for lymph nodes free of tubercles.

Recently Feldman and Baggenstoss reported the surprising positive findings of only four per cent of focal tubercles in children. Much of their material, however, was shipped to them in borax which may have been detrimental to some of the bacilli. Besides, when so many were selecting the material, there would not be a tendency to uniform sampling. Many of the less dense lesions may have been overlooked. The disparity, however, is certainly not entirely on such a technical basis. The facts seem to point more to a different type of material than was used before. Tubercles in children perhaps differ from those of older people. When such tubercles become encapsulated, most of them go on to healing and rather early sterilization. But if we accept their results at their face value, there is still the unsolved problem of lesions that produce disease later in life.

From pathological studies, Birsch-Hirschfield in 826 accidental deaths, reported that 20.7 per cent had tuberculous lesions with 4.2 per cent of them active. Reinhard found 36.1 per cent of the lesions "not healed" of 360 adults; Hart found 7.2 per cent active lesions in 573 soldiers; while the largest series of all was that of Robertson, who found 4.05 per cent active lesions in the 2.69 per cent with tuberculosis as the principal cause of death in 3306 autopsies at the Mayo Clinic. This work is significant because it is on a large series and the patients were representative of the whole country.

Clinically there have been numerous reports, most of which are well summarized by Sayé. Active disease (adjudged largely on x-ray examination), ranges from less than one per cent in America and many parts of Europe, to eight per cent in some parts of China. Recently Tice and associates found 4.3 per cent in a survey in a heavily infected district in Chicago.

As evident from the figures cited, as well as many more reports in the literature, there is a great deal of discrepancy in the findings, irrespective of the source or branch of science used to obtain them. They are perhaps due to differ-

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* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.

From City of Chicago Municipal Sanitarium, Research Laboratories.

Assisted by S. A. Levinson and Asya Stadnichenko (deceased), University of Illinois and Research and Educational Hospital.

ence in concept, difference in material from place to place, and especially from one era to another, and differences in training for a particular objective. For example, as Naegeli's technique improved, his percentage figures rose for positive findings from 75 to 90, to 97 and 98 per cent respectively. In fact, most people in that time must have had gross infection. Obviously there are less infections and less severe infections today than in Naegeli's time. With Naegeli's best technique today, it would not seem possible to find more than 70 per cent of our cases positive. The post mortem x-ray adds to the ease of finding very small lesions.

Another discrepancy in the early reports is in "active" lesions. Most pathologists found four to five per cent of their material positive, but here again figures vary widely; as pointed out by Opie, for clinical appraisal, the differences between latent and clinical tuberculosis have "no other basis than the limitations of diagnostic methods and the tendency of tuberculosis to proceed to recovery." The same indefinite line of demarkation also exists between the concepts of pathological activity. Some may call a lesion active with a thin capsule, others only with perifocal giant cells, while still others might demand soft caseous lesions. Roentgenological criteria of activity is even less accurate than either pathological or clinical.

One absolute criterion alone remains, viz: living tubercle bacilli *in* the lesions. Even this must be supported by collateral pathological findings such as a thin capsule, giant cells in or near the capsule, otherwise the bacilli may be from recent exogenous sources and may not lead to disease. *The presence of lesion-producing bacilli, however, is prima facie evidence of potential disease.*

Due to improvements in technique and by using every available means at our disposal, it was thought feasible and justifiable to try to clear up some of the discrepancies existing in the reported results of the past, and to discover any clews with respect to the exacerbation of the disease.

The present study was, therefore, planned to achieve that aim, although it was nearly ten years before it was an unqualified success. During the intervening time, several different attempts were made with meager or inconclusive results. The material was always difficult to obtain in sufficient quantity. Such a result is to be expected when it is necessary to depend upon people having no special interest in the work. Of 45 acceptable cases of these various attempts, however, five had positive cultures (11.1 per cent), a result that was an encouragement to further effort. The various attempts to carry out the work did help to develop a trained organization and a standardized technique which has contributed largely to the success of the venture. The work was finally reorganized about a year and a half ago with new objectives, a stabilized personnel, and an assurance of abundant material.

OBJECTIVES

The prime object of the work was to attempt to discover the incidence of infection as it exists today in people apparently well; the incidence of the disease in ill people but not having had a diagnosis or any recognized symptoms of tuberculosis; to see if anything could be determined regarding the mode of development of the disease; to see if the development of the disease could be related to any state or condition of the host with regard to age, race, sex, occupation or intercurrent diseases; to see if any means might be used during life to discover dangerous lesions by studying of histories, and from physical, x-ray and laboratory findings. In addition it was desirable to find if possible the relation of the presence of tubercle bacilli to the age and character of the lesions and to other disease processes and to pathological evidences of active tuberculosis near and away from the focal lesions. Finally, it was desirable to find the comparative value, if possible, of different culture methods, acid-fast staining, and fluoroscopic microscopy in the identification of the presence of living bacilli in tissues.

FACILITIES AND ACKNOWLEDGMENTS

As might be inferred from the preceding discussion, it was most important to have an uninterrupted flow of material, suitable laboratories with adequate supplies, and corps of trained workers.

The laboratories at the Municipal Tuberculosis Sanitarium afforded the facilities for carrying out the work, including bacteriological, pathological, x-ray equipment, and the materials necessary for these various operations. These facilities were made available by the authority of the Board of Directors, Dr. Frederick Tice, President; Mr. Harry Reynolds, Treasurer; Dr. Richard Davison, Secretary, and Dr. Leo M. Czaja, Superintendent of the Institution.

Much of the material was furnished by the Cook County Hospital Pathological Laboratory with the coöperation of Drs. Jack D. Kirshbaum and William P. Mavrelis. The Coroner's Pathological Laboratory and the Research Hospital Pathological Department also furnished much valuable material for study.

Special aid was also obtained from the Tuberculosis Institute of Chicago and Cook County.

The technical part of the culture work was carried out or supervised by Miss Asya Stadnichenko until she was forced out by illness and an untimely death. Since then her assistants, Messrs. William I. Lansford and John M. Kleech, and her sister Miss Vera Stadnichenko have carried on with no more interruptions than could be expected following such a misfortune.

The pathological section work has been carried out by Miss Alma Everett and her assistants.

The post mortem x-ray and liaison work has been done by Mr. Tom Cantalancio.

The photographs and illustrations have been

prepared by Mr. William L. M. Martinsen.

METHODS

The method of procedure was so organized that no two groups could know the results of any other until the final reports were obtained. The lungs were removed and x-rayed; the various lesions suspected of being tuberculous were charted on a stamped outline of the lungs. Each lesion was given a number. Any extra-pulmonary tuberculosis (and other disease) was also recorded. The various tuberculous lesions were then removed with sterilized instruments and placed in sterile bottles bearing the proper number of the tubercles on a label. The culturing process was carried out with sterilized equipment. The individual lesions were removed from the bottles by sterile forceps; the excess tissue was trimmed off and cultured for most of the first 200 cases. The practice was discontinued for reasons to be given later on in the work. The tubercle, with a small amount of tissue around, was cut in two with sterile scissors, one-half being placed in formaldehyde solution for section and the other in a sterile mortar and ground into an impulpable powder or magma for culture, smears and animal inoculation. The contents of the covered mortar were taken up in sterile salt solution and treated in the standard manner NaOH, HCl, or C_2H_{204} (and sometimes two of these substances) and planted on two to five culture bottles of three or four different media. The culture medium used was that of Saenz, Loewenstein's, modified by Jensen and Holmes, Wooly-Petrick, and sometimes a modified Sweany-Evanoff medium and Arena's medium. Each soft or semi-soft lesion was worked up separately and cultured. At least one guinea pig was used on the fresh lesions for each case. Old dense lesions of the same side were frequently pooled. The cultures were observed weekly after three weeks and were not rejected until six months' time had elapsed. The animals were killed and reëxamined after sixty days.

The specimens for pathological section were decalcified and stained first with H and E, but all tissues positive on culture were sectioned, stained and examined for tubercle bacilli. Many times recuts and partial serial sections were made.

The microscopical pathological examination included a detailed description of the pathological formations in the section with a rough estimation of the age of the lesions as outlined in a former study. Owing to the fact that half of the lesion was taken away from culture and usually only one section was examined, the analysis was less accurate than in previous work. As later results show, however, there was an interesting relationship of age to the number of positive cultures. The smears were examined completely for acid-fast bacilli on early type lesions. All old lesions were studied for at least fifteen minutes as routine.

All of this work was done without any knowledge concerning the patient. All of the clinical, pathological and x-ray data was compiled by another team of workers and the various findings finally fitted into a master chart.

EXPERIMENTAL RESULTS

This preliminary report involves only the first 300 completed cases of 800 cases already partly worked up.

Table I shows the division of the cases on the basis of the presence of, or the type of calcification. There were 37 lungs without any calcified lesion at all; and 51 in which the lesions were too small to divide successfully with scissors. The total of 88 unstudied specimens was 29.33 per cent, leaving 212 (70.67 per cent) that were studied. There were 23 cases in which no lesions were found having age characteristics suitable for analysis. Some were silicotics; others had "silicotic fibrosis" or other evidence of pneumoconiosis. Some were chondromas, or other calcified pathological lesions than tuberculosis; others were "fibroid caps"; while a few were not suitable for age analysis at all.

The results of search for evidence of tubercle bacilli in the 212 cases studied, are shown in table II. Acid-fast bacilli and positive cultures are compared and both are combined. There was 10.38 per cent positive for acid-fast bacilli, against 16.53 per cent positive cultures. Both together gave a positive finding of 20.75 per cent. There were 14 cases in which both were found positive; 21 positive on culture, but negative on smear; and 8 positive on smear but negative on culture. The total number of colonies averaged about ten times as many as there were acid-fast bacilli found. Since there was about ten times as much material used for cultures as was used for smears, the results were fairly comparable. There was not always agreement, however, of pathological lesions with positive culture and smears. It must be remembered that the parts saved for section were not cultured, and vice versa, and that many times tubercles have "budding" colonies only on one side. Furthermore, the sections made involved only one small portion of the half for section, while the culture represented practically all the half that was cultured. It may also be possible to have positive cultures without evidence of recent tubercle formation. Bacilli may possibly live for some time entirely encapsulated. The results, however, seem to indicate that the average time of survival isn't long, without producing tissue reaction.

In table III are arranged the 189 cases on which age analysis was possible on at least *one* lesion, with the positive findings recorded of the youngest lesion immediately below the percentages in the third line. In line four are cases having slight silicosis and line five are the corrected figures.

Outside of the cases having one or more silicotic lesions, the bacilli disappeared from tubercles rather rapidly and at a regular rate. Although

a few cases seem to show life in tubercles up to 10 years, the evidence indicates that enclosed lesions do not retain living bacilli long after two years and many become sterile after one year. The apparent persistence of the bacilli is due to the "spreading," "overflowing," or otherwise progressing lesions. Sometimes it may be confined to only one tubercle and even only a small part of one tubercle, but in such cases the bacilli escape the tubercles to lie dormant in the outer capsule or in the tissue beyond for long, or to form into new colonies which become encapsulated. The fact that we haven't always found the fresh colonies does not argue against their existence, because we only observed a small percentage of the surface of any one tubercle. One-half was cultured and a section was made of the other half that represented only a small per cent of all the surface.

The question of what causes the bacilli to survive or what causes the tubercles to weaken and disseminate the bacilli, is largely unanswered. It was at first suspected that silicotic fibrosis may be a dominant cause, but although high, a higher percentage of positives resulted from "ruptured" or "overflowing" lesions than from those having silicosis or "silicotic fibrosis." The only significance of small areas of silicosis appears to be that they afford a "hide out" for the bacilli. Disease comes only after a critical quantative threshold is reached.

Positive findings of pathologically active tuberculosis were present in three cases (1.41 per cent) of the 212 cases studied. One case was an old healing fibroid, another a progressive fibrocaseous infiltrate, and a third a miliary and acinous-nodose progressive tuberculosis in a child. This figure is low, because obvious and advanced tuberculosis was not given to us, and represents quiescent lesions only. In addition, there were 22 (10.38 per cent) cases in which there were definite evidences of progress of the disease around one or more of the calcified lesions as an overflowing or otherwise slowly progressive process. Of these 22 cases, 12 (54.54 per cent) have positive cultures. Only two of these lesions were of a silicotic nature. The cause of occult progression is still enigmatic. The bacilli may have gained more virulence; the host may have a temporary depression in resistance or an accident, disease, or drinking bout at a critical moment in the existence of the lesion.

The group of silicotic cases was of absorbing interest, not only from the standpoint of industrial medicine but more important from the mechanism of survival of the bacilli. The results are charted in table IV. There was one case of second-stage (diffuse type) silicosis, and two cases of typical first-stage silicosis, all of which were positive. Practically every lesion was positive with numerous colonies and acid-fast bacilli in smear. There was one case of silicotic fibrosis rather marked in some of the hilum lymph nodes, but no cultures were found positive. There were 11 cases with a few whorls of silicotic fibrosis in one or more lesions, two of which were positive, and 15 cases of similar type lesions except there was either much coal or iron pigment, or evidence of tuberculosis caseation present in addition. Five were positive. In 30 cases having slight or moderate silicosis 10 were positive (33.3 per cent).

The interesting feature was that in *none* of the "silicotic" lesions could there be found any recent signs of tuberculosis activity. The bacilli seemed to harbor in the old nodes and produce slight caseation and an "egg-shell" calcification but no cellular reaction. Perhaps the defense mechanism may have become exhausted within the nodules or the bacilli may be able to live without increasing much in numbers (until later in the disease). While the bacilli may survive in the lesions, there do not appear to be any more cases develop active tuberculosis than in other cases. The presence of bacilli, however, is admittedly a threat, but there was a lower percentage of positive findings in the silicotic types than in those showing incidence of a progressive disease. There seems to be a considerable degree of silicosis necessary before a progressive tuberculosis can develop.

Case No. 293, a first-stage silicosis, had lesions that were hard and fibrotic with very little tuberculosis in spite of strongly positive cultures. Case No. 169 was more tuberculous but still not caseous in an 84-year-old man. Had he lived twenty more years he might have died of silicosis.

Several things seems certain: Silicosis can develop without tuberculosis, but when tubercle bacilli come in they tend to remain for long intervals without eliciting any proliferative tissue activity or without appearing to grow extensively until the fibroid tissue "hideout" for the bacilli becomes extensive. Then the bacilli seem to be able to come out in the open and produce disease. All the implications of these observations, however, must await a final review of the whole series of cases before any final judgment can be passed, if then.

The same phenomenon of "dormant" bacilli seemed to exist in cancer tissue. Of five cases in which cancer tissue was found, two (40 per cent) were positive. The same principle may operate as in silicosis, viz: bacilli may survive in cancer tissue, but not grow. There is perhaps no tubercle-forming tissue in the cancer.

In a few cases of old fibroid lung tissue there also seemed to be living bacilli without tubercle. This fact was pointed out by Opie when he obtained growths in lung tissue around tubercles more than in the lesions themselves. It raised the question in his mind whether most of his infections were not coming from outside sources and not from the tubercles. While there is no doubt about a "tissue immunity" existing around tubercles or an "exhaustion" of the resisting forces as the old focus is approached, it cannot explain all the many lesions within the capsules nor the increasing of positive findings as the lesions de-

crease, in age. As in silicosis, in some cancer cases and some old fibroid lesions, there is a nominal percentage of bacilli from exogenous sources. In the oldest lesion groups there was a small percentage of positive findings. There are still residue infections, however, in the old tubercles that gradually diminish as the years pass. Some die out soon (perhaps as soon as one year) but a few by microscopic extensions persist for as long as five years or longer.

In this preliminary report many important details must be omitted, but a few general observations may be made. For example, there was a strong evidence of exogenous reinfection in 12 cases (5.9 per cent); seven (3.3 per cent) had clear-cut "reinfection complexes." Naturally there were more reinfections than this, but just because there happen to be soft lesions in the apexes and calcified lesions in the bases or at the hilum does not prove exogenous reinfection. Many times definite progression from one lesion to another can be traced (as in x-rays No.'s 225 and 235). One of the problems of this study has been to work out a rational means of tracing such infections in the body. Where the ages of the lesions are not widely different and where living bacilli can be found in the older lesions or the giant cells in the capsules, there is no justification in saying the soft lesion is from exogenous sources. It *may* be, but many times endogenous infection can be established without difficulty. Here again we are forced to wait for the complete and final study.

An important collateral observation was that in cases having signs of generalization, no living bacilli were found in any of the lesions. In two of the cases the lesions were less than two-year types, and two more were less than four. In these four cases giant cells were present in many of the lesions, but no positive culture or animal inoculation was obtained in spite of the fact that from 10 to 20 lesions were studied from each 10 guinea pigs and 242 culture bottles inoculated. It seems to suggest that mild generalization produces an unfavorable environment for tubercle bacilli. The findings are shown in table V.

Another important finding is of special interest to roentgenologists. There were 4.29 per cent calcified focal lesions that proved not to be tubercles, not including calcified bronchial cartilages. Among these, were four chondromas; two osteomas (these may have been very old tubercles); one calcified lipoma; one fibroma; one phlebolith, and one case of ossified fibrous tissue in an old fibroid apex. The last lesion showed ossified blood vessel walls and ossified hyaline connective tissue.

While there were many other minor pathological features of interest, there has been no attempt made to correlate the roentgenological findings or the clinical histories. That interesting data will be given in the complete report, together with a more exhaustive discussion of the results and their significance.

SUMMARY

A study has been made of lesions in the lungs and related lymph nodes of 300 patients dying of other conditions than tuberculosis.

Positive cultures were obtained in 16.53 per cent of 212 cases in which detailed studies were made. Of the same group, only 10.38 per cent showed acid-fast bacilli on smears, but they were not identical, as 21 cases (47.72 per cent of all positives) were positive on culture and negative on smears, and eight (18.18 per cent) were positive on smear and not on culture. Both methods together gave a positive result of 20.75 per cent.

When arranged according to the ages of the lesions there was a positive finding of 80 per cent of lesions less than one year, and a gradual drop of 23.1 per cent at the end of ten years. By deducting cases with silicotic or other interfering lesions, it causes the curve to reach an "irreducible" minimum much sooner. The presence of bacilli in the younger lesions is thought to be due to persistent and "overflowing" lesions, and to silicosis, cancer, etc. In a certain definite number of all lesions, and all "old" lesions, "dormant" bacilli are present from exogenous sources. The conclusions from all of these observations must await more seasoned study.

In seven cases where partial generalization occurred, no bacilli could be found in spite of the fact that in four of the cases the lesions were less than four years, and two had lesions appearing less than two years. It seems to offer a problem for immunologists.

Lesions having "budding" tubercles, "overflowing," or ruptured capsules, or giant cells in or just outside the capsules, contained more bacilli than in any other type.

Silicotic lesions or lesions having slight "silicotic fibrosis," were prone to contain tubercle bacilli more than the average lesions (33.3 per cent). This feature loses its principal significance since it is impossible to estimate the age of silicotic lesions.

Most tubercles gradually heal, beginning after a few months and continuing for seven to ten years, depending chiefly upon the number and persistence of the preceding changes.

There were 4.29 per cent of the "dense" calcified or partially calcified lesions which were not tubercles or silicotic nodules. They were chondromas, osteomas, lipomas, fibromas, phleboliths, etc. It illustrates the need for roentgenograms to study relationships and characters of densities in lung roentgenograms.

Tuberculosis control is a vital part of national defense, according to recent statements of the surgeons general of the U. S. Public Health Service, the Army and the Navy.

FEATURES OF THE EARLY PULMONARY INFILTRATION *

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THE greatest obstacle to understanding the behavior of the earliest lesions of pulmonary tuberculosis is their failure to sicken the host. Since, next to absolute prevention of infection, identification and proper management of the early lesion is the most effective means of attack on tuberculosis, the importance of a systematic study of groups of healthy people, among whom the disease may be expected at some future time, can easily be seen. Most published reports include observations of lesions by the x-ray while they are still undetectable by other methods. At Bellevue Hospital a study has been under way for more than thirteen years; the views which I am expressing here are based largely on this experience.

It has been variously stated that a person is unlikely to become a phthisic if he has passed the age of thirty or thirty-five without a demonstrable pulmonary lesion. If we except older people whose resistance has been depleted by uncontrolled diabetes, dietary deficiencies, alcoholism, and the like, the statement holds. Furthermore, it is observed that the lesions of progressive pulmonary tuberculosis usually do not appear until after the start of adolescence. In other words, it is the span of life between adolescence and the early thirties which may be watched with the best prospect of detecting the first appearance of these lesions.

How quickly a lesion may appear in a lung which previously was healthy on x-ray examination is still not very clear. To answer this nearly accurately would require an x-ray examination of a group of healthy young people every week for a number of years; obviously, an objectionable undertaking. However, certain implications are observed. Also, we are not prepared to say much about the relation of the early lesion to recent primary infection. In contrast, with young children, a peculiarity in young white adults, who were tuberculin negative, then became tuberculin positive, and still later developed pulmonary lesions, is the failure to demonstrate by x-ray a typical primary complex; visible enlargement of the regional lymph nodes usually is lacking. Consequently, because the frequency of tuberculin testing must be limited, it is seldom possible to judge clearly whether the lesion discovered is primary, or whether it represents an extension from the primary or an exogenous reinfection.

As to the pathological nature of the early lesion one must depend chiefly upon the interpretation of roentgenographic densities; this must be done with considerable reservation. In a relative minority of instances the pulmonary field, which on previous examination was clear, contains a new, round, discrete, nodular shadow, usually less than a centimeter in diameter, which conforms with that of a productive tubercle. This appearance may be deceptive because the roentgenographic density of small exudative lesions at their start may have little of the collateral haze which is one of the signs of this type of reaction; i.e., there may be a well defined border indicating the limitation of the inflammatory exudate within broncholobular walls rather than the periphery of a productive tubercle. The confusion is not so great in lesions more than a centimeter or so in diameter; first, because the larger the size, the more likely is the process to be wholly or partly of an exudative lobular pneumonic nature; second, because larger lesions usually cast shadows with soft hazy borders. Autopsy of many chronic tuberculous subjects verified the reliability of these criteria, by studying recent lesions of bronchogenic origin, the duration of which is fairly well known from antemortem observation. Thus, the conclusion: most early lesions are predominantly exudative.

Age and race have an important influence. The younger the subject, the more likely is a newly developed lesion to be exudative; this is somewhat more striking in adolescent girls than in boys, and in Negroes than whites. So many observations point this way that one is prompted to utter dictum: until careful observation proves otherwise, assume that a tuberculous lesion, newly developed in the lung of a previously healthy person, is an exudative infiltration and, therefore, potentially very unstable.

The term, infiltration,[1] is aptly applied to the exudative lobular pneumonic or bronchopneumonic lesion. Morphologically, it has the same connotation now as it had when first used by Laennec to distinguish it from the tubercle. The distinction is fundamentally important because of the different potentialities. Whatever the underlying cause may be, the productive (miliary or conglomerate) tubercle tends to follow a mild and indolent course, enlarging and undergoing caseation and excavation slowly; whereas the infiltration (gelatinous or gray) is much more labile, frequently spreading and breaking down rapidly. Similarly the infiltrate may become absorbed much more rapidly than the productive tubercle; or the serous and cellular elements at the periphery of the infiltrate may be absorbed while the liquefied caseous center is excavated.

In retrospect, one may find in a previous roentgenogram a tiny focus which presumably may have been the precursor of the early infiltration, but, without a knowledge of subsequent events, the diagnosis of tubercle, rather than blood vessel, would have been highly imaginative. Nevertheless, there is much to suggest that many recognizable early lesions are in reality extensions from preëxisting occult foci. What we call "early" applies only to that which is demon-

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strable. It is a relative term which once referred to the lesion initiating symptoms, but now, to that casting an identifiable roentgenographic shadow.

Knowing that exudative infiltrations inevitably change progressively or retrogressively, we have paid particular attention to the later evolution of those discovered early. The dominant trend of extensive pneumonic infiltrations to caseation and excavation has been noted by clinicians generally. Small early infiltrations behave in a similar way, the one apparent difference being quantitative; central necrosis is the striking tendency. This is so common as to suggest that almost all early lesions are caseous at the center by the time they can be diagnosed by x-ray. The cavity, when present, is often so minute that it can scarcely be recognized in the roentgenogram; special techniques may be required. That the pinhead or pea-sized rarefactions usually denote excavation is verified by their later enlargement and, as a rule, by the demonstration of tubercle bacilli in the scanty sputum or in the gastric washings upon meticulous examination.

The behavior of the periphery of the early infiltration is conditioned largely upon the rate and extent of the central caseation, the apparent reason being that the former depends upon the rate of manufacture in and local diffusion of toxic substances from the latter. If caseation is minimal and sloughs out early, the peripheral exudate is likely to be absorbed rapidly, and the minute cavity may close promptly; secondary bronchogenic lesions are slight or absent. If caseation is rapid and extensive, peripheral extension is greater; when the liquefied matter is discharged into the bronchial tubes extensive, even lobar pneumonic, secondary lesions may result. If caseation is small or moderate in extent (usually not more than 1 or 2 cm. in cross-section) and becomes arrested with little or no ulceration into the bronchus, the peripheral exudate may be gradually absorbed and organized, encapsulating the cheesy residues; roentgenographically, these often have the appearance of so-called "round infiltrates."

The rate and succession of these changes varies greatly. At the start of our study the usual routine of making roentgenographic observations once a month or so was followed. Soon it was found that some lesions changed markedly in this interval. Now it is routine, upon discovering a newly developed lesion in a previously healthy person, to make the examination every week during the first one or two months. Occasionally an interval of several days is the limit. It has been discovered, especially in adolescent and young adult patients, that a cavity, 2 or 3 cm. in diameter, may appear within a week; and infiltration 1 cm. in diameter may double or triple its size in one to four weeks; an infiltration 1 to 2 cm. in diameter may abruptly discharge its liquefied caseous contents into the bronchi, thus inciting an acute tuberculous lobar pneumonia within two or four weeks. Some early infiltrations remain stationary for weeks or months, then rapidly change with excavation and numerous and extensive secondary lesions. The transition from the early lesion to advanced bilateral disease, in exceptional cases, is a matter of only a few weeks. Resolution, when it occurs, is slow. At first the peripheral exudate, perhaps quite serous, may absorb rapidly but as a rule the process slows as the core of the lesion is approached. In several months minute residues remain, almost naked caseous remnants which may be visualized as collections of myriad organisms, delicately imprisoned, waiting for some passing disturbance to spread them far and wide. The warm, fertile lung is ever receptive for the threatened dissemination. During the subsequent two years, approximately, circumstances decide whether wide destruction is initiated, whether the slow process of fibrous encapsulation may become competent and permanent, or whether an indecisive balance between the forces of destruction and repair leaves the lesions in that uncertain and sad state, known as chronicity.

A most interesting observation is the lag between pathological morphological change and systemic effects. For example, upon first discovering an early infiltration the erythrocyte sedimentation rate usually is reported normal. During the subsequent few weeks a steady or intermittent extension of the lesion, perhaps the excavation, may occur without any coincidental change in this test. Then as the pulmonary involvement continues the sedimentation rate for the first time is accelerated; a few days or weeks later the initial fever may be detected. One may interpret this to mean that the diffusion of toxins must persist and reach a considerable level before the systemic effects are measurable by the ordinary clinical and laboratory tests. In some cases tubercle bacilli are discovered in the sputum before these effects are detected.

Certain implications are suggested. In all probability a tuberculous infiltration may develop in the lung within a few days to several weeks. That this may be the first demonstrable extension from a preëxisting occult focus cannot be denied.

When an infiltration is fresh, with only minimal central caseation, the possibility of resolution and complete healing is greater than it is at any subsequent phase of the disease. Conceivably, conditions would be more favorable if the small caseous core had been extruded, but this seldom occurs without some infection of the surrounding parenchyma.

The opportune time for securing maximal effects of treatment is in this early phase, preferably before there are any severe systemic symptoms and before secondary bronchogenic lesions have had time to develop. To wait for the lesion to give indubitable evidence of its "activity" usually means that the best opportunity for cure

has been lost. Fortunately, this does not imply that an "arrestment" may not occur later. But, to accomplish the most for the patient, the fact must frequently be emphasized and well remembered that a small lesion, demonstrable only by x-ray and wholly symptomless, may be an early infiltration with serious and closely impending potentialities. Unless it is unmistakably fibroid, such a small lesion at the start should be observed roentgenographically at weekly to biweekly intervals. Preferably, the patient should be on rest treatment while this is done. These conceptions have proved, in our experience, to be a sound basis of treatment with results surpassing any other scheme which we have tried. The experience seems to indicate that, if the conceptions could be applied generally, tuberculosis would seldom become the advanced and fatal disease with which, regrettably, we are so familiar.

SUMMARY

The behavior of the earliest lesions of pulmonary tuberculosis can be understood only by a systematic study of apparently healthy people among whom the disease may be expected to appear. The period of life between the start of adolescence and the age of thirty or thirty-five is the time during which most of these lesions first develop.

Most lesions of the early infiltration are a predominantly exudative, lobular pneumonic character; this type of tissue reaction is most conspicuous in adolescents, especially in young girls and in Negroes. The assumption should be made, until well proved otherwise, that this type of reaction prevails, remembering that the roentgenographic appearance may be misleading.

The striking tendency of the early infiltration is to progress to the point of caseation and excavation. Close study demonstrates that such changes may be rapid; e.g., a small lesion may enlarge, caseate, and slough out within a week or two, and give rise to extensive secondary bronchogenic lesions.

Usually, systemic effects such as fever and an accelerated erythrocyte sedimentation rate, are not apparent at the time of the early infiltration and there is often a considerable lag in these effects while the lesion is advancing.

It may be inferred that the early infiltration may develop within a few days or weeks in the lung of a previously healthy person. There is reason to believe that in many or most instances there have been preëxisting occult foci which served as points of origin.

Treatment is most successful if it is based on these conceptions; usually, advanced tuberculosis can be avoided.

1. The term *"infiltration"* refers to the *process* by which the tissue is invaded by tuberculous inflammation, while the term *"infiltrate"* is used to indicate the lesion produced by the process.

HAEMOTOGENOUS PULMONARY MANIFESTATIONS IN EXTRAPULMONARY TUBERCULOSIS*

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TO determine the form of pulmonary pathology existing in association with extrapulmonary tuberculosis, the chest films of 100 unselected patients with extrapulmonary tuberculosis were analyzed.

For comparison and in order to weigh the practical import of results, another 100 cases of routine adult pulmonary tuberculosis, with no evidence of extrapulmonary foci, were reviewed.

In the group of 100 patients with extrapulmonary tuberculosis, 79 showed x-ray evidence of post-primary pulmonary involvement. In 21 of the cases there was no x-ray evidence of a post-primary lesion and in only eight of these there was evidence of primary involvement. Although a certain percentage of primary lesions are hidden behind the mediastinal structures and the domes of the diaphragm, and some of them may have resorbed completely, there is also the possibility of some portal of entry other than the lungs. At any rate the absence of a pulmonary post-primary or primary tuberculous lesion does not necessarily exclude an extrapulmonary focus.

The majority of the pulmonary lesions in the 79 cases were fibrotic and calcific, apparently inactive; proliferative, nodular, and exudative manifestations were decreasingly common in that order. A miliary distribution of lesions was seen in 12 instances, seven of these being acute miliary generalizations and five of chronic nature. Lesions interpreted as of fibrotic character were seen in 37 patients and in 24 of these fibrosis was the predominant feature. Calcification was observed in 35 instances and in 12 of these it was the predominant lesion. The character of these lesions and the tendency toward bilateral, symmetrical, apical and subapical distribution, seen in 44 of the 79 cases indicates a haematogenous origin and emphasizes the systemic nature of the disease.

There was roentgenographic evidence of cavitation in 15 patients. These cavities were mostly thin walled with bilateral symmetrical distribution. In spite of the fact that in 12 cases the sputum was positive for tubercle bacilli and that these patients had pulmonary symptoms, only one had evidence of bronchogenic spread.

In cases in which multiple films were available, stability or regression of the pulmonary lesion and absence of bronchogenic spread were the outstanding features. This was true even of those cases where cavities were present. Though progressive pulmonary lesions did occur, for the

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Abstract.
From Los Angeles County General Hospital.

inter-lobar fissures, etc. Part of it may be ascribed, however, to the lessened absorptive capacity of the lymphatics in the thickened pleurae.

Histological examination of the tissues after such injections showed that though many of the lymph vessels and nodes contained talc bearing macrophages, some thorotrast was also present in these structures. Some thorotrast, therefore, was able to pass along the lymphatics, despite apparent filling of the latter by talc. The talc-filled lymphatics had been occupied or distended, but not completely blocked, by the talc. The thorotrast injected after a talc pleuritis had been induced, however, tended to remain in the periphery of the lymph vessels and nodes, rather than to pass toward the center with the talc previously administered.

A similar picture was observed when the thorotrast was injected following the production of tuberculosis by intrapleural injection. Here the parietal lymph nodes and granulations were outlined on the x-ray by a thin layer of thorotrast, giving an interesting delineation of their location and extent. Histological sections showed that the thorotrast, in these cases, also passed through the lymph vessels and around the lymph nodes.

This property of thorotrast of outlining previous pathological lesions in the pleural cavity may be of interest and even of value. The delineation of intrapleural metastatic malignancy was suggested as one possibility, similar to the demonstration of intraabdominal malignancy by thorotrast. The delineation of the character and extent of pleural adhesions and of their pleural lymphatic connections may also be feasible. The possibilities of such work, however, their advantages, disadvantages, technique, indications and contraindications, all remain for future investigations. It is hoped that this demonstration of the manner in which thorotrast may be used in the visualization of pleural lymphatics may aid in stimulating further work in this direction.

SURGICAL ASPECTS OF PLEURAL ADHESIONS*

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IT IS agreed that the effectiveness of pneumothorax is in direct proportion to the completeness of the collapse of the tuberculous lesion. About one-fifth of all attempts at artificial pneumothorax fail and between 40 and 50 per cent of pneumothoraces established are either incomplete, inadequate or ineffective because of isolated adhesions. Complete and concentric collapse and relaxation of the diseased lobe or lung is necessary if effective treatment is to be obtained.

Experience has shown that adhesions preventing perfect collapse may gradually stretch or rupture in a few weeks or months. Should adequate collapse not be accomplished in the first six months the collapse will probably remain inadequate but no definite time can be set. Frequently extensive adhesions show a steady yielding which justifies a continuation of pneumothorax. It is generally agreed that intrapleural pneumonolysis should not be employed until the pneumothorax has been present for from three to six months, but that it is indicated earlier when needed to control severe hemoptysis, pain, or protracted or violent coughing. It should also be used earlier when apparently operable adhesions are holding open cortical cavities surrounded by exudative lesions in order to eradicate the trauma on the diseased portion of the lung during respiration. In cases in which early release of adhesions is demanded but dangers of pneumonolysis are too great, as in acute pleuritis, immediate temporary phrenic paralysis may be used. However, phrenic paralysis, in my opinion, is no substitute for closed pneumonolysis.

The desirability of thoracoplasty over closed intrapleural pneumonolysis is still a discussed question. In cases in which adhesions appear to be inoperable or their division extremely dangerous and difficult and attended with great risk of post-operative complications with small likelihood of resultant adequate collapse, thoracoplasty should be chosen. The majority of surgeons prefer pneumonolysis in cases presenting operable adhesions over pulmonary lesions that will probably respond to subsequent pneumothorax. In some cases, too, thoracoplasty is contraindicated by virtue of contralateral pulmonary disease.

Not all adhesions need be divided. Those producing tension on non-cavernous and exudative lesions if divisible should be operated; also, adhesions on areas previously containing cavity or active lesions. The earliest possible conversion of sputum is of utmost importance to the patient. Such conversion of sputum is a more accurate determination of effective collapse than is roentgenologic evidence.

The only absolute contraindication to intrapleural pneumonolysis is mixed infected tuberculous empyema and a progressive obliterative pleuritis. Active lesions in the contralateral lung provided they are presumably curable with or without collapse therapy are aided by complete collapse of the "bad" lung. Usually there is no indication for collapse therapy on the contralateral lung until complete collapse of the worst lesion has been accomplished. Bilateral collapse is no contraindication provided the vital capacity of the patient is sufficient to withstand the increase in collapse. Serous effusion or even pure tuberculous empyema does not constitute contraindication unless an acute or subacute pleuritis be present. Ordinarily, thoracoplasty is preferable when the pleura is studded with tubercles but pneumonolysis is possible if it can be done without disturbing the tubercles.

The final decision of the operability of adhesions cannot be made except by careful scrutiny

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.
From College of Medical Evangelists, Los Angeles, California.

most part they were of haematogenous origin.

Of the cases with but one chest film available, the majority were interpreted as of chronic nature.

The following features, as determined from this study, may be listed as characterizing the pulmonary pathology associated with extrapulmonary tuberculosis: (a) Predominance of fibrocalcific lesions, apparently inactive; (b) bilateral, symmetrical, apical and subapical distribution indicative of haematogenous origin; (c) cavities, when present, thin walled and with tendency to symmetrical distribution; (d) relative absence of bronchogenic dissemination; (e) evidence of regression or stability in the pulmonary lesion with superimposed haematogenous spread a not uncommon feature.

Review of the chest films of 100 control patients admitted because of pulmonary symptoms and without clinical evidence of extrapulmonary tuberculosis, emphasized the acute exudato-caseous nature of the usual adult pulmonary tuberculosis with its tendence to bronchogenic spread. Eighty-three cases exhibited exudative lesions, 70 of them predominantly so. Although this preponderance of acute exudato-caseous lesions with rapid spread was to be expected in view of the many emergent cases admitted, the pulmonary pathology of this group differed so markedly from that of the group with extrapulmonary tuberculosis as to permit a valid comparison.

A small percentage of the patients without evidence of extrapulmonary tuberculosis exhibited a pulmonary picture similar to that found in the group with extrapulmonary tuberculosis. These few cases demonstrated bilateral symmetrical lesions with tendency to chronic course and absence of bronchogenic spread. In a few instances, cavitation of the thin walled variety with marked tendency to contraction and healing was also noted.

It seems that the dissemination of bacilli, resulting in extrapulmonary lesions and in many cases associated pulmonary pathology with a strong tendency toward benign chronic course, produces some form of immunological response bringing about increased resistance.

THE LYMPHATIC DRAINAGE OF THE PLEURA AS DEMONSTRATED BY THOROTRAST*

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FINE particles of thorium dioxide (Thorotrast) injected into the body are taken up by lymphatics, which consequently become radioopaque. Their distribution, then, as seen in the x-ray film and confirmed by histological examinations, is similar to that of india ink, carmine and other fine particulate or colloidal substances. It varies, accordingly, with the route of injection and the exact site of the tissues into which the material is placed. An extensive series of such injections performed here on hundreds of animals, including mice, hamsters, guinea pigs, rats and rabbits, have confirmed in most respects the findings of other workers in this regard.

Thorotrast injected intrapleurally appeared in the diaphragmatic sulcus, over the surface of the lung, and in the inter-lobar fissures. X-ray examination showed vertical densities, which did not correspond to normal lymphatics but represented, instead, superimposed boundaries of the various lobes of the lungs. Dissection of the separated lobes of the lungs showed thorotrast fixed on the visceral pleura, in lines and patches, irregularly. On section, part of it was within preformed lymphatics, part in new formed spaces, and part in placques overlying the pleura. The thorotrast granules were, for the most part, packed in large macrophages or surrounded by them.

There were accumulations of thorotrast in lymph nodes or aggregates of lymphoid tissue on the visceral pleura, as well as in lymph spaces or vessels, but practically none within the parenchymal pulmonary tissues. In the chest wall the thorotrast appeared in horizontal lines between the ribs corresponding to the intercostal lymphatics which drain the parietal pleura. Often two such lines were seen in an interspace. Nodules or patches were seen along these lines, and sometimes the nodules were present when the lines could not be recognized. In addition, following intrapleural injection of thorotrast, many opacities were seen in the mediastinum. These correspond to the substernal, parasternal, hilar and paravertebral lymph nodes, and varied in size, density and number.

The aseptic pleuritis produced in various animal species following the intrapleural injection of talc, thymol, iodide, bismuth formic iodide, iodized oils, gomenol, etc., has been studied extensively in the hope that it might prove of value. It was observed, however, that this procedure is followed by increased spread of tuberculosis from later intrapleural infection. The suggestion that this might be ascribed to blocking of the lymphatics and consequent lack of protective encapsulation was further explored by means of the thorotrast technique.

Accordingly, thorotrast was injected intrapleurally in rabbits which had previously been treated by the intrapleural injection of talc or other substances. X-ray examination showed that the thorotrast following talc showed a tendency to remain at the site of injection and that absorption along the lymph vessels and into the lymph nodes was much less marked than in the controls. Some of this greater localization was probably due to adhesions, obliterative pleuritis which lessened the size of the pleural space into which the thorotrast was deposited, the obliteration of

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Abstract.
From the Laboratories of the Rose Lampert Graff Foundation and Olive View Sanatorium.
Assisted by Lillian Sherman, M. A., Nathan Hiatt, M. D., and Emil Bogen, M. D.

aureus empyema two-and-one-half months after pneumonolysis, was tube-drained, given a phrenic paralysis; on bed rest his lower lobe cavernous lesion healed, the lung re-expanded and the empyema healed solidly.

In the 21 arrested cases, the patients are still carrying pneumothorax, although several are about ready for re-expansion. Among this group are four bilateral pneumothoraces. They are all leading normal lives; they have been negative to all sputum and gastric examinations for over a year to five years, and their x-rays show arrested lesions, without apparent activity. One of these patients had no adhesions severed, but pneumothorax was pushed.

In the one apparently arrested case, the patient has been negative to all tests for 10 months, and negative to all tests except gastric guinea pig inoculations for two years previous to that; his x-rays show no active lesion, and he has been on one or two hours exercise twice a day for many months.

In the one quiescent case, the patient is ambulatory, has no activity by roentgenograms, has an excellent collapse except for one remaining inoperable adhesion close to the mediastinum, and has been positive only to guinea pig inoculation for a year and half.

In the one case improved, the patient had all fourteen adhesions divided at operation, and has an excellent collapse except at the base. She looks and feels well, does a moderate amount of housework, but her cultures are still intermittently positive.

The only death in the series was that of a patient re-admitted with a six-and-one-half-year old pneumothorax for thoracoplasty. It was found no adhesions were suitable for division so nothing was done. She had far-advanced bilateral tuberculosis from which she died in another sanatorium three-and-one-half years later. The thoracoscopy had no ill effects.

The majority (27 cases) had adhesions divided within the first twelve months of pneumothorax and of these 11 are apparently cured, 14 are arrested, 1 is improved and 1, quiescent.

In 36 of the 38 cases, all or the major portion of adhesions were divided and in two cases only thoracoscopy was performed without event. Of these 36 cases, all adhesions were divided in 18 cases (50 per cent) and the major portion of the adhesions were cauterized in 18 cases (50 per cent). We advocate early (within six months) pneumonolysis. This small series fails to bear out its advantages, but a larger series might possibly do so. It is noteworthy that of the entire series of thoracoscopies (38) only two were wholly inoperable.

TIME OF SPUTUM CONVERSION

There were 34 patients in whom adhesions were divided, who converted their sputum, became apparently cured (13 cases), arrested (20 cases), or apparently arrested (one case). Twenty-one of these patients had unilateral disease and converted their sputum in an average of five and one-half months after pneumonolysis, with the exception of one patient with ipsilateral tracheobronchial tuberculosis who took four years for permanent conversion, in spite of complete collapse of the lung after division of all ten adhesions. Seven of the 21 had an immediate conversion of sputum following pneumonolysis. In the remaining 12 converted cases bilateral active disease was present at the time of pneumonolysis, and in six of them bilateral pneumothorax was required, although none of them had bilateral pneumonolyses; this group required an average of 23 months to become negative. There were, of course, no immediate conversions of sputum in this group. It might be added that in the entire series the sputum was positive at the time pneumonolysis was performed. In this group, also, there was no notable difference in the conversion time of those operated within six months and one year after pneumothorax was instituted and those operated over a year after the pneumothorax was begun.

POSTOPERATIVE COMPLICATIONS OF 38 THORACOSCOPIES

One patient developed obliterative pleuritis and pneumothorax was lost; thoracoplasty was substituted 19 months after pneumonolysis. He never has had a positive sputum since his surgery and is apparently cured.

One patient developed staphylococcus aureus empyema suddenly 10 weeks after pneumonolysis and was tube-drained. He already had a phrenic paralysis which has left the diaphragm in a high fixed position. On bed rest the lung re-expanded, the empyema healed solidly, a cavity in the left lower lobe closed, and he has been apparently cured for almost three years.

Slight moderate and usually localized subcutaneous emphysema is found in the majority of cases if it is looked for. In none was it large in amount or in any way troublesome to the patient.

There was no hemorrhage at the time of surgery or any evidence of post-operative bleeding in any of the cases.

Dyspnea, bronchopleural fistula, pleurocutaneous sinus or nerve injury did not occur.

Twenty of the 38 patients (52.6 per cent) developed slight transient effusion following thoracoplasty and pneumonolysis, all of which absorbed in from eight to twelve weeks without aspiration. Three patients (8 per cent) had a seropurulent effusion (positive for tubercle bacilli) at the time of pneumonolysis; in one, the effusion disappeared following operation; in two, it has been persistent but in such small quantities as to require aspiration rarely.

Three patients (8 per cent) developed tuberculous effusion many months following pneumonolysis and required aspiration at intervals of several months, but in no case has it been alarmingly rapid or in large amounts and there has

of the entire field through the thoracoscope. Some adhesions may not be seen on the roentgenogram and apparent adhesions seen on the roentgenogram may prove to be ridges of parietal pleura leading to lung diffusely adherent to the chest wall.

The simple method of Jacobeus still remains the most practical and popular technique of pneumonolysis. I personally prefer the simple galvanocautery and two puncture method. The galvanocautery is less expensive than the electrosurgical instrument; it is simple, easy to keep in order and cheaper to repair. Also the degree of heat is simpler to control and it is less painful to the patient when cauterizing close to and in the parietal pleura. The apparatus is also easy to transport from one sanatorium to another. The incidence of pleural effusion and of hemorrhage is no greater although it is easier to control bleeding and oozing with the high frequency coagulation. The two cannula method gives a wider range of vision and greater freedom for work; it also will carry all instruments. The site of puncture is variable. Following a pneumothorax refill a day or two previously, fluoroscopy or roentgenography will usually reveal a free space for the introduction of the first cannula in the fourth, fifth or sixth intercostal space in the midaxilla. Through a one and one-half centimeter incision in the skin and subcutaneous tissues, the trocar, cannula and thoracoscope are introduced, the pleural cavity explored, and the site of introduction of the second cannula determined. If the adhesions are extensive, it is better for both the surgeon and the patient to divide the operation into two or more stages. The skill and patience of the surgeon at all times must be at its optimum and a two-stage operation is less tiring to both surgeon and patient. One of the most important rules of the operation is to know when to stop, both in time and type of adhesions to be divided. Unless the surgeon is sure, after a thoracoscopic examination, that enough adhesions can be divided to control the lesion and to insure satisfactory collapse, he should cauterize none at all.

Thorough knowledge not only of the anatomy of the pleural cavity but also of the pathologic anatomy of pleuropulmonary adhesions is essential to successful pneumonolysis. The condition of the endothoracic fascia is an important criterion.

Postoperative complications: A moderate amount of subcutaneous empyema around the areas of introduction of the cannulas may be present but usually disappears within three days. In one-third of the cases a slight to moderate transient serous or sanguinoserous effusion will appear which disappears in two to four weeks. Aspiration of residual fluid and blood clot before withdrawing the cannulas will reduce materially the incidence of postoperative effusion and fever.

The incidence of tuberculous empyema is less than would follow lack of control of lesions by incomplete pneumothorax. Mixed infected tuberculous empyema is a serious complication. The etiology is usually a bronchopleural or pleurocutaneous fistula rather than an infection due to "break in technique." Hemorrhage is not a frequent complication. Oozing from puncture wounds or bleeding from a branch of the intercostal vessels during dissection is easily controlled. Hemorrhage necessitating thoracotomy is rare. A pneumothorax may be lost by leakage of air through the cannula track or as a result of an obliterative pleuritis. Air replacement at frequent intervals is indicated for the former. Obliterative pleuritis is not common, but its incidence is definitely higher than in unoperated pneumothoraces.

Open pneumonolysis is a major procedure which carries with it potentially serious dangers and should not be considered a substitute for the closed method. It should be reserved for that small group of cases in which closed pneumonolysis and phrenic nerve paralysis have failed and in which thoracoplasty is contraindicated.

Results cannot be based on the success or failure to divide adhesions but must be evaluated by extensive workup and complete follow-up data of each case. Such complete data was obtained in all of the 38 cases which constituted my series at the Barlow Sanatorium during the years 1936 and 1939 inclusive. Although the series is too small to allow definite conclusion to be drawn, we believe the results are worth reporting.

In this series of cases, when sputum is referred to as negative, it includes cultures and guinea pig inoculations of both the sputum and fasting gastric contents unless otherwise specified. In referring to conversion of sputum, it is specifically implied that the sputum and the gastric contents are converted to "negative for tubercle bacilli" by flotation, culture and guinea pig inoculation, the date of conversion being estimated to be the date of first negative cultures after the last date of finding of tubercle bacilli by any method.

TABLE I

Results of 38 thoracoscopies at Barlow Sanatorium 1936-1939 (inclusive)

Apparently Cured	Apparently Arrested	Quiescent	Improved	Dead
13 (34.2%)	*21 (55.2%)	1 (2.6%)	1 (2.6%)	1 (2.6%)	*1 (2.6%)

* Two of the 38 cases (one arrested and one dead) had thoracoscopy only without ill effect, the remaing 36 cases had all or the major portion of adhesions severed.

The 13 apparently cured patients are well, and are leading normal lives; their sputums and gastric contents are negative, there is no evidence of activity by x-rays and their lungs are all expanded, including two bilateral pneumothoraces. In one of the bilateral cases both lungs were collapsed for four years; in the other, for four and six years. In nine of the unilateral cases pneumothorax was carried for their full term of collapse before re-expansion was allowed. One developed an obliterative pleuritis nineteen months after division of adhesions and had a three-stage thoracoplasty without event. In the remaining unilateral case, the patient developed acute staphylococcus

been no interference with the carrying on of the pneumothorax.

SUMMARY

The importance of converting an inadequate pneumothorax into an effective complete collapse by severing adhesions even in the so-called "symptom free" patient is stressed; and the importance of frequently repeated careful and extensive sputum examinations to determine the date of a lesion's arrest is discussed, as is the evaluation of roentgenographic series before and after collapse therapy has been instituted. Results of closed intrapleural pneumonolysis are given along with operative and post-operative complications.

ARTIFICIAL PNEUMOTHORAX FOR TUBERCULOUS PNEUMONIAS *

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WHILE all tuberculous lesions of the lung are initially of pneumonic character, the term tuberculous pneumonia predicates an acute lesion more or less sharply localized within the lung or its lobar subdivisions. In essence it represents a caseous or gelatinous consolidation, the result of a bronchogenic dissemination from pre-existent parenchymal or bronchial lesions. For this reason the distribution is circumscribed rather than widespread in the respiratory parenchyma.

Pathologically, tuberculous pneumonia partakes of the nature of all the acute ulcerative forms of pulmonary tuberculosis, but with an accelerated tempo in its pathogenesis, that has earned for it the synonyms "galloping consumption" and "phthisis florida." Progressive and regressive phases, and resolution with fibrosis and calcification exist simultaneously. Clinically, the patient is, as a rule, acutely sick. Prostration and the depletion of bodily reserves bespeak an unfavorable prognosis.

The plan of the therapeutic campaign should be the product of the integration of certain values and considerations, many of which are imponderable.

The clinical condition of the patient as it reflects his response to the new invasion, the degree of prostration and physical depletion may argue for a *noli me tangere* attitude. Extremes of reaction, clinically speaking, reflect not so much the extent of the lesion as the response to lesion. In fulminant cases, therefore, the judgment as to where and how to interfere should lean to the side of conservatism. A preliminary "cooling off" period under conditions of basal rest and supportive measures has much in its favor.

Provided the intensity of the new infection lies within tolerable limits for the individual, thoracic lymphatics play a vital rôle in the isolation of invading organisms from the new field of spread. The integrity of this defense, in its intact state, particularly in younger individuals where the lymph and vascular architecture is less apt to be modified by precedent infection, and/or the attacks of environment, has been seen to effect a rescue in pneumonic phthisis, unaided by measures other than rest.

In not a few tuberculous pneumonias there is a predominance of either the productive or exudative phase. When a solid, caseous lobe is encountered, obviously an artificial pneumothorax cannot achieve a collapse. The detelectasis of the exudative type, while it may likewise caseate, commonly undergoes spontaneous resolution as the productive phase begins to wane.

Epituberculosis, especially when extensive, lends itself poorly to air collapse, since it represents an airless state of the parenchyma engendered by an interstitial compressive edema. Precipitate induction of artificial pneumothorax as it is applied to minimal or moderately advanced discrete lesions, tends to yield an organized, cornified and non-expansile lung. Associated as it is with profound toxic manifestations, attempted collapse in lesions of this type affects only the circumjacent normal tissue, with subsequent increased anoxia and misery to the patient.

A supplemental measure that has proved of value in the "cooling off" period has been the induction of artificial pneumoperitoneum, particularly where the lesion is basal, or at least in the lower half of the lung. This therapeutic measure permits a revokable procedure which provides lung relaxation without the profound modification of intrathoracic pressure relationships that obtain in artificial pneumothorax as ordinarily administered. The augmented lung rest so obtained during the "cooling off" period advances the arrival of a break in the septic swing of the fever. The criterion for intrathoracic air collapse of the affected lung had best be defined as the period when clearing of the lesion is roentgenologically evident. No arbitrary period can be set, but the lull in the storm may not transpire under three months from the onset of the explosive phase.

Where pneumonic processes occupy the upper half of a lung field, the choice of conservative interference may be in the direction of a controlled or fractional artificial pneumothorax. In contradistinction to the conversion pneumothorax, where cavity closure and sputum conversion is the goal, fractional artificial pneumothorax aims at a degree of lung relaxation compatible with the least interference with uninvolved respiratory tissue and lymph flow, plus a moderate circulatory hyperemia. Frequent small refills tend to maintain a just appreciable pneumothorax space under fluoroscopic control. Excessive adhesion formation is obviated. In the event of favorable regressive changes, a conversion collapse becomes feasible.

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Abstract, panel discussion.
From Fairmont Hospital, San Leandro, California.

In instances of double or bilateral tuberculous pneumonia, where the prognosis is usually unhappy, pneumoperitoneum alone would seem to be the operation of choice, irrespective of localization of lesions.

It is unfortunate that our sanatorium classifications and disease indices show a lack of precision in the exact classification of the various types of lesions falling under the heading of tuberculous pneumonia. Without a definite breakdown into types of lesions, it is most difficult to evaluate selectively. The seeker after information is defeated beforehand by the amount of work involved in culling a large enough group of selected cases over a given period of time.

SUMMARY

1. The prognosis in tuberculous pneumonia is grave. In bilateral cases especially so.
2. A preliminary "cooling off" period of basal rest, supplemented by pneumoperitoneum is desirable.
3. The length of the period of conservative therapy should be determined both by the clinical picture, and by frequent serial roentgen examinations.
4. Conversion pneumothorax is contraindicated for the immediate treatment of the extensively involved and fulminant case.
5. Fractional artificial pneumothorax may be advantageously employed in unilateral apical involvement.
6. Bilateral tuberculous pneumonias demand pneumoperitoneum alone, if any form of collapse therapy is considered applicable.

PLEURAL EFFUSIONS COMPLICATING PNEUMOTHORAX*

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Olive View

IT is reported that more than half of all pleural effusions complicating induced pneumothorax arise during the first six months of pneumothorax therapy, that from 15 to 25 per cent of all serous effusions eventually become purulent, and that from 40 to 100 per cent of purulent effusions begin as serous effusions. The findings in a series of 41 patients with pleural effusions support these figures.

The series consisted of one group of 21 patients, in whom effusion developed; and one group of 20 patients, in whom the effusion had been noted on an average of five months before coming on my wards. Sixty per cent of all effusions developed within the first six months of pneumothorax therapy, the average interval between induction of pneumothorax and the onset of effusion for the entire series being exactly six months.

Prior to the onset of effusion, the great majority of patients had far-advanced bilateral pulmonary disease and positive sputum. All but one had mechanically unsatisfactory collapse and patent cavitation and one-third also had contralateral cavitation. This 97 per cent incidence of mechanically unsatisfactory collapse is suggestive of etiological connection (Table I).

A more immediate and direct cause of the effusion was obvious only in a small fraction of the series. The onset was febrile in 26 of the 32 cases; the average maximum temperature was 102 degrees and the average duration of fever two and one-half weeks. In all patients in whom the effusion became purulent, and the type of onset of effusion was known, it was found to be febrile.

The study demonstrated the universally serous onset of effusion and the subsequent conversion to purulent fluid in 33 per cent of patients. In about 75 per cent of patients, tubercle bacilli were found in the effusion. In patients in whom the onset of effusion was febrile, the incidence of fluid positive for tubercle bacilli was three times as great as in patients in whom the onset was afebrile. Pyogenic cultures were negative throughout (Table II).

To prevent the various complications of pleural effusions, all patients were treated by frequent aspirations and most of those with purulent fluid also by intrapleural instillation of neoprontosil (Table III).

End-results regarding pneumothorax and effu-

TABLE I
Status Prior to Onset of Effusion

Group and No. of Pts.	N. T. A. Classification		Distribution of Disease		Cavitation		Sputum		Type of Pneumothorax		Average Duration of Pneumo. (months)
									Mechanically		
	MA	FA	Unilateral	Bilateral	Collapsed Lung	Uncollapsed Lung	+	−	Satisfactory	Unsatisfactory	
I 21	6	15	10	11	21	9	13	8	1	20	8
II 20	2	18	7	13	20	4	18	2	0	20	4
I and II 41	8	33	17	24	41	13	31	10	1	40	6

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Abstract, panel discussion.
From Olive View Sanatorium.

sion at the time of death, or at discharge from Olive View Sanatorium and in March, 1942, for those still at Olive View, reveal pneumothorax was maintained in about one-half of the patients, the great majority of whom achieved cavity closure and sputum conversion in spite of the fact that in three-fourths of the cases collapse was still mechanically unsatisfactory. Fluid persisted in only three out of the total of 41 patients and then only in small amounts. The average number of months since final aspiration was 14 for the entire series (Table IV).

In those in whom pneumothorax was maintained even though the amount of collapse at termination of treatment was practically the same as prior to onset of effusion, the average size of refills and their frequency decreased and the average intrapleural pressures at the end of refills rose to become positive. This suggests that, at least in this series, positive intrapleural pressure is a result and not a cause of the pleural effusion.

In comparing the clinical end-results with the pre-effusion status, we observe, (1) cavity clos-

TABLE II
Pleural Effusions
(all negative for pyogens on culture)

Group and No. of Pts.	Type of Effusion at Onset		Subsequent Conversion to Purulent Fluid	Tubercle Bacilli							
				+	−	Number of Specimens Examined; Methods and Results					
						Smear		Culture		G. Pig	
	Serous	Purulent				+	−	+	−	+	−
I 21	21	0	2	14	7	3	53	24	27	6	10
II 20	18	?	11	16	4	23	54	27	15	4	1
I and II 41	39	..	13	30	11	26	107	51	42	10	11

TABLE III
Treatment of Pleural Effusions

Group and No. of Pts.	Average Interval between Onset of Effusion and Aspiration (weeks)	Pneumothorax		Average					Intrapleural Medication	
		M	Not M	Number of Aspir.	Number of Mos. of Aspir.	Frequency of Aspir. (days)	Total Volume Aspirated (c.c.)	Volume per Aspiration (c.c.)	S	P
I 21	2	20	1	8	2	10	1000	125	0	A–1 M–1
II 20	6 (for 10 Pts.)	10	10	23	6	9	2000	90	0	A–1 N–10
I and II 41	3 (for 31 Pts.)	30	11	15	4	10	1500	100	0	A–2 M–1 N–10

"M"—maintained; "S"—serous; "P"—purulent; "A"—alcohol 95%.
"M"—merthiolate solution, 1:5000; "N"—Neoprontosil solution, 2½–5%.

TABLE IV
End-Results of Pneumothorax and Effusion
(at time of death in, or discharge from Olive View Sanatorium and March 1942 for those still in Olive View Sanatorium)

Group and No. of Pts	Fate of Pneumothorax			Type of Pneumothorax Maintained		Fate of Effusion		Average Number of Months since Last Aspiration
				Mechanically				
	Maintained	Discontinued	Lost	Satisfactory	Unsatisfactory	+	−	
I 21	13	4	4	4	9	1	20	14
II 20	7	13	0	1	6	2	18	14
I and II 41	20	17	4	5	15	3	38	14

TABLE V
Clinical End-Results
(at time of death in, or discharge from Olive View Sanatorium and March 1942 for those still in Olive View Sanatorium)

Group and No. of Pts.	N. T. A. Classification		Distribution of Disease		Cavitation		Sputum		Clinical Status (N. T. A.)					
	MA	FA	Unilateral	Bilateral	Collapsed Lung	Uncollapsed Lung	+	−	D	U	I	Q	AA	A
I 21	6 (M-1)	14	8	13	5	3	6	15	2	3	2	3	9	2
II 20	3	17	9	11	2	1	4	16	0	1	1	6	10	2
I and II 41	10	31	17	24	7	4	10	31	2	4	3	9	19	4

ure and sputum conversion in over three-fourths of the cases and (2) arrest or apparent arrest of disease in more than half. Of the 23 arrested or apparently arrested cases, three had a homolateral and one contralateral thoracoplasty; another five thoracoplasty patients were operated on too recently to be rated better than quiescent. Pulmonary cavitation and not empyema was the indication for thoracoplasty in all nine patients but an additional thoracoplasty stage to obliterate the empyema pocket was done in two cases and was successful in only one (Table V).

In reducing the incidence of tuberculous empyema in artificial pneumothorax, two procedures are suggested: (1) discontinuance of ineffective pneumothoraces as soon as the ineffectiveness of complementary collapse measures has been demonstrated; and (2) treatment of serous effusions of 100 cc. or more by frequent aspirations as they must be regarded as potential empyemas.

PNEUMOTHORAX IN THE OLDER AGE GROUP *

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In a group of 89 patients, varying in age from 43 to 65, pneumothorax was attempted. Cases were selected on the usual criteria for artificial pneumothorax, primarily unilateral state of the disease, presence of cavity and/or positive sputum. Forty of these cases were in the 5th decade of life, 41 in the 6th decade, and eight in the 7th decade. All but six were far advanced, and all but 10 presented cavities.

A pneumothorax pocket was established in 62 individuals, including two bilateral cases. Attempt at pneumothorax was unsuccessful in 27 cases due to adhesions; in 34 individuals the pneumothorax was abandoned in less than one year as ineffectual. Fluid was aspirated in only 15 cases; in only four did empyema develop. Spontaneous pneumothorax occurred in five patients. Adhesions were noted in 33 cases. In four cases pneumonolysis was performed, in two of whom the pneumothorax was considered effective; in another, fluid followed and the space was converted into an oleothorax. In 20 cases the pneumothorax pocket was supplemented by a phrenic crush.

The results of treatment in cases in which pneumothorax was established, as compared with the group in which it failed, were as follows:

	Pneumothorax Pocket		Pleural Synthesis	
Arrested	6	10%	4	15%
Improved	11	18%	5	18%
Unimproved ..	27	43%	8	30%
Dead	18	29%	10	37%
Total	62		27	

SUMMARY AND CONCLUSIONS

The results show little difference between the two groups. This small series suggests: Pneumothorax effective in only 16 per cent of these patients; obliterated pleural space prevented establishment of pneumothorax in 30 per cent of these older patients; complications to pneumothorax here were not serious; other forms of collapse such as phrenic crush and/or pneumoperitoneum were as effective as pneumothorax; careful consideration of the physiologic status of the patients in the older age group should be given before attempting to establish pneumothorax.

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract, panel discussion.
From Olive View Sanatorium, Olive View, California.

PNEUMOTHORAX IN THE TREATMENT OF ACUTE MINIMAL TUBERCULOSIS *

Edwin G. Kirby, M.D.
San Diego

In ITS most characteristic connotation, the term acute minimal tuberculosis implies a recent, or relatively recent small area of pulmonary infiltration without cavitation. This lesion is most

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Abstract, panel discussion.
From Vauclain Home, San Diego.

often found beneath the clavicle or in the first or second anterior interspace and is described by the roentgenologist as "soft."

Typically, we might expect the patient to be a healthy-appearing adolescent or young adult who has been in direct contact with a case of active tuberculosis. Cough, sputum, hemotysis or other classical symptoms have usually not appeared. Constitutional symptoms are absent or are limited to malaise, anorexia or slight weight loss. Careful physical examination of the chest is usually negative. The Mantoux test is positive, while the sputum or gastric contents may or may not be positive.

Although the foregoing might be described as "typical," each individual case represents a problem for the physician to solve, not only on the basis of his experience in the usual methods of treatment, but also on his knowledge of the social background, economic status and psychological make-up of his patient. Such important considerations as age, sex, race, occupation, co-existing diseases and length of exposure to tuberculosis must be carefully weighed.

To obtain this information, a period of observation at basal conditions, i.e., absolute bed rest is essential. Whenever possible, this period should be spent in a hospital for the tuberculous, away from the distracting influences of the family. This period, as pointed out by Hegner, should be measured in terms of weeks rather than months.

Occasionally, a lesion which roentgenologically seems entirely typical, will clear in the space of two or three weeks, indicating a mistaken diagnosis.

The acute early infiltrate is always an unstable lesion, it soon regresses or progresses. Absorption or fibrosis may follow; or there may be rapid or slow progression with caseation, liquefaction and excavation.

The indications for pneumothorax are numerous, but in my opinion, the following are the most important. The production of positive sputum indicates that tissue necrosis has already occurred, and for this reason, these cases should be given pneumothorax promptly. Likewise, lesions with x-ray evidence of beginning breakdown should be collapsed immediately.

If the lesion continues to progress on bed rest, immediate collapse is indicated, even though the sputum remains negative. In addition to serial x-rays; careful pulse, temperature and respiration records, sedimentation index and differential white count are valuable indices of the patient's course under therapy.

There are supplementary, more personal indications for pneumothorax which have not been mentioned so prominently in the literature. The family wage-earner may prefer immediate collapse and the attendant shorter period of hospitalization and disability to the more conservative, if equally effective period of absolute bed rest.

Likewise, the non-coöperative, the unintelligent, or the trouble-making patient may be much better controlled by pneumothorax. In our experience, the most difficult patient to handle in the sanatorium is the apparently healthy individual with no symptoms. He finds it boring to maintain himself at bed rest and all too frequently leaves the hospital against medical advice. We have many times started pneumothorax because we have concluded that it was the only way to control both the patient and his lesion.

The adolescent girl with minimal tuberculosis requires especially close observation, and if there is any question as to lack of satisfactory progress, pneumothorax should be done.

Turner and Collins have listed as advantages of pneumothorax in these cases, the shorter period of hospitalization and disability, the shorter conversion time in case the sputum is positive and the fact that in their opinion, the end results are better. It should also be emphasized that the doctor sees his pneumothorax cases oftener and any change will be detected sooner. He is likewise in a better position to regulate their social and vocational activities.

The chief arguments against pneumothorax are: the inconvenience to the patient, the necessity for the long and expensive period of treatment and, most important, the danger of complications. While the latter are rare in minimal cases, pleural effusions, empyema, spontaneous pneumothorax, bronchopleural fistula and non-expansile lung do occur.

SUMMARY

Beginning tissue necrosis, positive sputum and lesions which are progressive on absolute bed rest, are, in my opinion, absolute indications for pneumothorax.

There is no such thing as a "routine" treatment for minimal tuberculosis. It is equally absurd to say that every case should receive pneumothorax as it is to say that collapse should never be used until the disease becomes moderately or far advanced.

Once a small area of pulmonary infiltration has been definitely diagnosed as being tuberculous, the patient should be treated for *tuberculosis*, and not for a "spot on the lung." There are too many patients with "spots on the lung" who only discover that they have tuberculosis when referred to a specialist after their disease has progressed beyond the minimal stage.

If the "early diagnosis" campaign is justified as it most assuredly is, then an "early and adequate treatment" campaign is likewise indicated.

The adequate treatment of acute minimal tuberculosis does not consist in merely telling the patient to "take it easy." It demands a period of absolute inactivity supplemented by pneumothorax or other collapse procedures as deemed advisable by the attending physician.

It is good business to spend money to wipe out tuberculosis. It would be far cheaper in the end than to go on bearing the terrific cost of caring for the tuberculous.

SILENT SPONTANEOUS PNEUMOTHORAX*

A. E. T. Rogers, M. D.
Olive View

TYPICAL diagnostic symptoms and signs of spontaneous pneumothorax are briefly enumerated; conditions in the chest which tend to mask these signs or cause confusing clinical pictures resembling extra-thoracic complications are mentioned.

Three illustrative cases are presented; a case of spontaneous pneumothorax without symptoms, recognized only at autopsy; one in which physical findings suggest intra-cranial pathology, with no abnormal signs found on examination of the chest; and a case with symptoms suggesting an acute abdominal episode, but with physical signs diagnostic of spontaneous pneumothorax.

It is emphasized that the occurrence of any acute complication in the course of pulmonary tuberculosis or of pneumothorax therapy should arouse suspicion of spontaneous pneumothorax; physical signs may be misleading, and fluoroscopy, radiography and diagnostic aspiration should be resorted to in an effort to establish or rule out the existence of a pneumothorax space.

EXTRAPLEURAL PNEUMOTHORAX**

Elliott P. Smart, M. D.
Murphys

IN view of the interest in the reports of last year, we are taking this opportunity to bring our report up to date. Our enthusiasm for the procedure in properly selected cases continues unabated. Lesions collapsed have been uniformly controlled. Those having persisting positive sputum have invariably had bilateral lesions.

We feel that oleothorax represents a very satisfactory method of conversion but it must be carefully supervised. It has been our experience that the symptoms encountered when the pressure in the space is too great or too little are the same, i.e., a feeling of tightness. The pressure can only be determined by actually checking it with a needle and adjusting it.

The report on the cases, illustrated by lantern slides show in the following tables:

Slide No. 1

Operations	Patients
Total—47	Total—43
1938	10
1939	15
1940	13
1941	7
1942	2

Slide No. 2

Operations	Fluid
Total—47	Total—13
Clear	8
Purulent	5
Transiently purulent	2

Slide No. 3

Operations	Oleothoraces
Total—47	Total—20
Tolerant	18
Intolerant	2

Frequently a small amount of clear fluid forms during the conversion but this practically always disappears with the completion of the oleothorax.

Slide No. 4

Complications	Total
Dissection of space with oil	1
Broncho pleural fistula	1
Air embolus transitory	1
Pyogenic infection	2
Hemorrhage into space P. O.	3
Extrapleural cutaneous fistula	1

Slide No. 5

Sputum

Sputum positive in all cases prior to surgery

Total Cases—43

Negative sputum	38
Positive sputum	5

Two of the five positive cases are recently post-operative.

Slide No. 6

Immediate Post-operative Care

Aspiration:
First ..... 48 hrs. P.O.
Second ..... 96 hrs. P.O.

Removal of all sanguinous fluid available. Replace one-half amount of air and then check pressure and adjust to positive 10 cm. water.

Slide No. 7

Present Status

No. of Pts.	'38	'39	'40	'41	'42	Total	%
Working	7	8	7	2		24	56
Rehab.		3	2			5	12
Conval.	1	1	3	2	2	9	21
Active	1		1	2		4	9
Dead *		1				1	2

* Death in one case due to abdominal pathology.

Slide No. 8

This slide showed a sketch of patient lying on side, shoulders on one table and hips on another, showing aspiration from beneath patient, demonstrating two fluid levels of varying densities within extrapleural pocket.

PROGRESSIVE PRIMARY TUBERCULOSIS *

Jesse D. Cook, M. D.
Olive View

A PULMONARY primary complex comprises the parenchymal site first infected together with the lymphatic glands, usually hilar, enlarged from draining it. When the primary complex is fully formed, the further course usually is to retrogress. In a test series taken consecutively, progressing cases comprised less than one per cent. Other instances of primary progressive tuberculosis were not so diagnosed on admission, but were recognized on later review.

According to Auerbach, usually the primary focus and the hilar glands enlarge; though in about one-fourth of the cases, only the latter. If there is erosion, whether from parenchymal focus or hilar glands, resulting in canalicular spreads, the foci caused are relatively large and are distributed according to chance anatomic connection. Lympho-haematogenous spread, a very frequent occurrence, results in smaller foci, widely distributed; aside from the lungs and meninges, this distribution occurs in the spleen, kidneys, adrenals, and liver.

Causes given for progression in primary tuberculosis are: early and repeated massive infection; concurrent disease of a type inhibiting allergy, (e.g. measles); race, (e.g. negroes); bad economic conditions and poor hygiene.

The unqualified statement is made that there are but two sure ways to diagnose progressive

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* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

** Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract, panel discussion.
From Bret Harte Sanatorium, Murphys, California.
Assisted by G. W. Prince, M. D., Stockton, California.

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* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

primary tuberculosis—(1) post-mortem, where by the microscope and absence of calcification the lesions are proved throughout to be of the same age; and (2) by a series of skin tests and chest films showing the same result.

A typical case: Mexican girl, seventeen years old, had an attack of "flu" in March, 1936; positive sputum in May, 1936; entered Olive View, June, 1936, showing tuberculous involvement of the left upper lung field and hilar enlargement; slight fever on admission; within seven months increased to septic type and so continued until just before death. Serial films showed gradual enlargement of left paratracheal and bronchial pulmonary masses and extension of parenchymal density in the left upper lobe, but no cavitation. Cervical lymph nodes were enlarged and given x-ray treatment without effect. A phrenic crush and attempt at pneumothorax were of no avail. Following gastro-intestinal symptoms and downhill course, patient died in July, 1937, less than eighteen months after reported onset.

Autopsy showed progressive primary type tuberculous lesions of the left lung, tuberculosis of tonsils and intestines, massive tuberculous adenitis of the lymph nodes draining all these structures, and scattered tubercle in the liver and spleen.

A STUDY OF SANATORIUM DISCHARGE STANDARDS FOR TUBERCULOUS PATIENTS *

INA GOURLEY, M. D.
Livermore

IN the course of treating the tuberculous patient, many questions arise. Many questions as yet have no satisfactory answer. One of these concerns the proper time for discharging the patient from the sanatorium. In an attempt to throw some light on the problem two things have been done. First, questionnaires have been sent to sanatoria asking about their discharge standards; second, our own standards have been checked by means of gastric lavage on a small group of discharged patients.

Thirty questionnaires were sent out. Of these, 21 were returned with sufficient answers to be of help.

The first group of questions has to do with the treatment of primary pleurisy with effusion. The questions are: How long are these patients kept in the sanatorium? How long are they kept on complete bed rest?

REPLIES TO QUESTIONNAIRES

The majority of the institutions are treating primary pleurisy with effusion intensively. One of the sanatoria does not admit uncomplicated effusion cases because of heavy demand on beds. Fifteen, or 75 per cent, give a total stay of six or more months. Five, or 25 per cent, give a shorter stay in the sanatoria, or determine the length of stay on circumstances of the individual case. Thirteen, or 65 per cent, keep them on bed rest three to six months. Seven, or 35 per cent, keep them in bed approximately two months, or until fluid clears.

TABLE I

Duration of Santorium care of primary pleurisy with effusion cases.

	Total Sanatorium Stay		Complete Bed Rest	
20 Sanatoria	6 months or more	Less than 6 months	3 to 6 months	2 months or until fluid clears
	15 or 75%	5 or 25%	13 or 65%	7 or 35%

The second group of questions refers to the length of sanatorium care of tuberculous patients after parenchymal lesions appear stationary on x-ray, all cavities closed and sputum is negative. Six of the physicians found the problems of their patients so varied that they were unable to answer these questions on length of stay. Fifteen of these 21 gave approximate lengths of stay.

The question: How long are patients treated by bed rest without collapse therapy, kept in these sanatoria after x-ray shows cavities are closed, lesions stationary and sputum negative? Four of these 15 sanatoria, or 26 per cent, keep these rest-therapy patients one to six months, and eleven, or 74 per cent, keep them six to twelve months.

TABLE II

Lengths of stay of bed rest patients after x-ray lesions stationary and sputum negative

15	1 to 6 months	6 to 12 months
Sanatoria	4 or 26%	11 or 74%

The sanatoria reporting the shortest length of stay after negative sputum are the sanatoria with the most rigid interpretations of negative sputum.

Patients with unilateral tuberculosis treated by bed rest plus pneumothorax are kept one to six months in 11, or 73 per cent, of the 15 sanatoria studied; and six or more months in four, or 27 per cent of the sanatoria, after cavities are closed and sputum is negative.

Patients with bilateral pulmonary tuberculosis are kept about the same length of time after sputum conversion, regardless whether they are treated by unilateral or bilateral pneumothorax. Nine, or 60 per cent, of the sanatoria keep them one to six months; and six, or 40 per cent, keep them six or more months.

Patients treated by pneumoperitoneum or pneumoperitoneum plus phrenic crush are given a slightly longer stay than those with bilateral disease treated by pneumothorax. Two sanatoria studied do not use pneumoperitoneum.

Patients treated by thoracoplasty are kept three to six months after the last stage of thoracoplasty by six, or 40 per cent, of the sanatoria, and more than six months by nine, or 60 per cent.

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* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.
Digest.
From Arroyo Del Valle Sanatorium, Livermore, California.

TABLE III

Length of stay of collapse therapy cases in sanatoria after x-ray lesions stationary, cavities closed and sputum negative. 15 sanatoria report:

Unilateral Disease with Pneumothorax		Bilateral Disease Unilateral or Bilateral Pneumothorax		Thoracoplasty	
1 to 6 months	6 months or more	1 to 6 months	6 months months	3 to 6 months	6 or more months
11 or 75%	4 or 27%	9 or 60%	6 or 40%	6 or 40%	9 or 60%

All of the 21 questionnaires give answers to the third group of questions on interpretation of negative sputum. There are 16 different answers. Five are in favor of three-day cultures. The 16 different answers vary from culture of a single morning specimen to an exhaustive study of each patient's sputum by direct smear, flotation, culture and repeated guinea pig inoculation of gastric contents. If the patient's sputum is negative by all these tests, an effort is then made to collect all of his sputum for 30 days and the sediment is injected into a guinea pig. Needless to say, this is a very wide difference in standards. Six, or 28 per cent, of the 21 sanatoria make gastric lavage with culture or guinea pig inoculation a discharge routine. Uniform discharge standards do not exist among these sanatoria because of the lack of agreement on when sputum has become negative.

Most of the sanatoria, however, meet the minimal laboratory standards as published in the report of the Committee on Standard Laboratory Procedure of the American Trudeau Society. This report appeared in the American Review of Tuberculosis, January, 1942, and is as follows: "For classification for discharge and for prognosis, as a negative sputum case, but not necessarily arrested: Three successive 24-hour concentrations at intervals of not more than a week . . . where facilities permit, a culture or animal inoculation is recommended with concentration."

The second portion of this paper has to do with an evaluation of our discharge standards. They are as follows: Primary pleurisy with effusion cases are kept on complete bed rest six months and may be given a work-up of a month or sent home for the work-up period, depending on circumstances. Patients with parenchymal lesions are kept in the sanatorium approximately three months after lesions are stationary, cavities closed, and sputum negative, regardless whether they have been treated by bed-rest, unilateral or bilateral pneumothorax or pneumoperitoneum. Patients treated by thoracoplasty are kept six months after surgery is completed. Our interpretation of a negative sputum is a one-week concentration and microscopic examination. Gastric lavage is not a discharge requirement.

With these standards in mind, 44 tuberculous patients were studied at the time of discharge by gastric lavage and guinea pig inoculations. All of these patients had some form of collapse therapy. There was almost an equal number of men and women. The men ranged in age from 17 to 49 years. The women ranged from 13 to 54 years. Twenty-nine of the 44 were of the white race; the remaining 15 were Negroes, Mexicans and Orientals. Twenty-seven of these 44 cases received unilateral or bilateral pneumothorax. Twenty-two, or 81 per cent, had negative gastric contents on guinea pig inoculation. Five, or 19 per cent, had positive gastric contents. Of five pneumothorax patients with positive gastric contents, four had lesions in the uncollapsed lung.

Eight of the cases received pneumoperitoneum; four, or 50 per cent, had negative gastric contents. Thoracoplasties were done on six of the 44 cases. Three, or 50 per cent, were negative. Two cases that were treated by pneumothorax plus phrenic crush and pneumoperitoneum received gastric lavage. One was negative. These two cases each had a large cavity off the lower pole of the right hilum which could not close by pneumothorax alone. The one additional case in the 44 had a very extensive tuberculosis treated by pneumothorax, pneumonolysis and oleothorax. The gastric contents were positive. Of the 44 cases, 30, or 68 per cent, had negative gastric contents; 14 cases, 32 per cent, had positive gastric lavage.

TABLE IV

Results of gastric lavage and guinea pig inoculations on 44 sputum negative discharge cases.

	Negative	Positive
Pneumothorax—27 cases	22 or 81%	5 or 19%
Pneumoperitoneum—8 cases...	4 or 50%	4 or 50%
Thoracoplasty—6 cases	3 or 50%	3 or 50%

Since patients discharged with pneumothorax showed 81 per cent negative gastric lavage and those discharged with pneumoperitoneum or thoracoplasty had only 50 per cent negative findings, something should be said about the extent of pathology in these groups. The pneumothorax patients were far advanced in only 25 per cent of the cases. The pneumoperitoneum cases were 50 percent far advanced. Patients discharged with thoracoplasty were 100 per cent far advanced. In addition 50 per cent of the thoracoplasties had some degree of bronchial stenosis seen in bronchoscopy.

Obviously, this group of 44 cases is too small to allow any conclusive statements.

SUMMARY

1. A study of discharge standards in 21 sanatoria was made by questionnaire. Length of stay in sanatoria after x-ray lesions are stationary, cavities closed and sputum "negative" was compared.

2. Interpretation of the term "negative sputum" was studied.

3. Our own discharge standards were stated. Results of gastric lavage and guinea pig inoculation on 44 discharged patients who were either sputum free or who had been negative on a one-week sputum concentration and microscopic examination were reported.

CONCLUSIONS

1. The 21 sanatoria studied lack uniformity of discharge standards because of lack of agree-

ment on the term "negative sputum." Three-day concentrations with culture is the most usual test applied.

2. Of 44 of our discharge patients 30, or 68 per cent, had negative gastric lavage on guinea pig inoculation.

3. Patients discharged with pneumothorax showed 81 per cent negative gastric lavage. Patients with pneumoperitoneum and thoracoplasty had 50 per cent negative gastric lavage.

INDICATIONS FOR LOBECTOMY IN INSTITUTIONS**

JANE SKILLEN, M. D.
Olive View

IN 1939, Drs. J. J. Jones and Frank Dolley gave five indications for lobectomy in tuberculosis: (1) frequent, huge hemorrhage not otherwise controlled; (2) suppurating lung complicating tuberculosis; (3) persistent cavity with positive sputum following extensive thoracoplasty; (4) indurated, atelectatic, firmly contracted honeycombed lobe with positive sputum; (5) unilobar basal cavities which do not heal after the usual procedures of collapse therapy have been employed. Suspected malignancy in tuberculosis may be added.

Contraindications include active contralateral lesions, poor condition of the patient, and the absence of adequate attempts at other surgical measures.

This series of lobectomies consists of 4 cases with no deaths. The first patient was sent out for the operation to the Cedars of Lebanon Hospital in 1935 and has been reported by Drs. Jones and Dolley. Of the 3 lobectomies performed at Olive View, 2 were done in 1941 and 1 in 1942.

Our indications were (1) hemorrhage with suspicion of malignancy, (2) positive sputum from atelectatic upper lobe, following thoracoplasty, (3) large upper lobe cavity following a three stage thoracoplasty and (4) cavity remaining open after a three stage and anterior thoracoplasty.

DOMICILIARY CARE IN OLIVE VIEW INSTITUTIONS *

J. DWIGHT DAVIS, M. D.
Olive View

A CASE of pulmonary tuberculosis with silicosis and many extrapulmonary complications, under institutional care for nearly a decade, is described. General and vague complaints are common in this type of patient. Very little medical and nursing care is required. A few of these individuals are chronically too ill to attempt any occupational therapy. Yet they must remain isolated. These are the "forgotten men." Because these individuals must be institutionalized over a period of many years they become discouraged. They must remain under isolation in an institution as they have no home facilities available which would be approved by the health department. They are placed in the institution under an isolation order. We as physicians must realize this, and treat these cases differently than the more acutely ill. Our responsibility is great.

In July, 1941, Olive View assumed an old C.C.C. Camp, which had been transferred to the Department of Institutions. Accommodations were quite inadequate, toilet facilities remote and an infirmary was available for only four patients. Infirmary units for 60 patients are being constructed; also available is bed capacity for 188 chronic cases. A garden project is contemplated. There are also a carpenter shop and shoe repair shop. Assignment of hours is planned for all ambulatory cases.

In addition to Olive View Camp at Acton, care is also given in several contract institutions, known collectively as the Olive View Outside Sanatoria. Those requiring bed care receive adequate attention in these institutions. Minimum standards have been established by Olive View for their care. Visiting physicians are assigned to various institutions. A mobile x-ray unit is employed and x-rays are taken at four-month intervals, or as indicated. Sputum specimens are collected routinely at four-month intervals and brought to Olive View for examination. Our full laboratory facilities are available for the Outside Sanatoria. Attending physicians see the cases in consultation, as at Olive View, and the same type of clinical conference is held for the staff.

Other groups of patients may be admitted to the Outside Sanatoria, such as: (1) Gravely ill patients, who have yet a life expectancy of some months, but in whom all methods of treatment have failed; (2) pneumothorax or other collapse therapy cases, who have shown satisfactory progress but still need further sanatorium care; (3) cases in which future surgery is indicated but in whom present contralateral lung disease precluded immediate operation.

The isolation of these chronic cases from the community eradicates a great potential source of tuberculous infection.

The annual death toll from tuberculosis in the United States would be more than 250,000 if the death rate of the early 1900's still prevailed. Under present mortality conditions, the annual death toll is about 60,000.

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Control of tuberculosis demands not only everything the medical profession has to offer, but also active participation by the public.

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* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

** Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

THE SIGNIFICANCE OF A POSITIVE GASTRIC LAVAGE CULTURE ON DISCHARGE *

JOSEPH L. ROBINSON, M. D.
Olive View

A STUDY is presented of readmission rates for patients discharged from Olive View Sanatorium after gastric lavage examination. Of 307 patients discharged before January 1, 1941, 16 or 5.2 per cent have been readmitted. Those whose gastric lavage was negative before discharge show a readmission rate of 2.4 per cent, as compared to 17.4 per cent for those with a positive culture on discharge. Cavitation, and/or positive sputum, was present at the time of readmission in six of ten patients who had been discharged with a positive gastric lavage culture; in three, of six discharged with negative culture.

THE PROGNOSIS OF THE SO-CALLED "GOOD CHRONIC"**

FRANCIS M. JOHNSON, M. D.
Olive View

PROFESSOR Archibald apparently was the first to employ the term "good chronic case" in tuberculosis. Brown and Sampson suggested as criteria for a "good chronic" case that a "cavity two centimeters or more must be present. General condition must be favorable. Temperature and pulse must be normal over a period of several months. Appetite and strength must be good and the patient able to take some exercise. Expectoration may be present but not excessive." The number of tubercle bacilli in the sputum is not taken into consideration. It should be noted that this grouping of patients is based mainly upon clinical data.

Chronic fibroid pulmonary tuberculosis represents the pathology in the majority of these patients. Production of fibrous tissue is the predominant characteristic, due to the age of the lesion. Tuberculous complications occur less frequently than in the more acute forms. The symptoms are, with few exceptions, not pronounced. The majority of these patients give a history of illness extending over a period of ten or fifteen years. Treatment is mainly symptomatic, but some of these individuals may become candidates for thoracic surgery.

Patients are rarely free from symptoms and never well; most of the time they are able to be up and around and with symptomatic care are kept comfortable. Isolation is necessary in most cases.

* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

** Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

THE PULMONARY ASPECTS OF CYSTIC FIBROSIS OF THE PANCREAS*

LLOYD B. DICKEY, M. D.
San Francisco

THIS entity has been recognized for some years, but I do not believe it has ever been formally discussed before this group. The respiratory symptoms and signs are the most startling part of the picture, and if these be present the prognosis is poor. The symptoms always develop in the first year of life, the patient is usually seen by the general practitioner or pediatrician first, and by the phthisiologist usually only in consultation. In any patient under two years of age, with a chronic respiratory infection extending from the tip of the nose to the alveoli, with sputum and a negative tuberculin reaction, cystic fibrosis should be thought of immediately, despite the fact that the diagnosis is made often only after necropsy. If suspected at all, the diagnosis can be made during life if a careful history be taken, and can be confirmed in many cases previously diagnosed as "chronic, or unresolved pneumonias," if the pancreas be sectioned at necropsy.

The first description of the pancreatic lesion was recorded by Landsteiner in 1905. In 1913, Garrod and Hurtley made a careful clinical study of a case of congenital steatorrhea in a boy of six whose brother died of bronchopneumonia at eleven months, after an infancy characterized by steatorrhea. No post-mortem examinations were recorded. Passini reported the first case of steatorrhea associated with a proved pancreatic lesion, the patient dying of bronchopneumonia at nine months. Necropsy demonstrated a fibrotic pancreas with acinar cysts. Siwe, in 1932, Benoit in 1935, and Tilling examined cases and confirmed diagnoses by examining the duodenal contents for pancreatic enzymes. On our cases we had not the facilities for these examinations. In 1938, Anderson reviewed the literature and reported cases. She considered the steatorrhea consequent upon the pancreatic deficiency as the cause of the deficiency of Vitamin A, and probably of D. She described the changes in the bronchial mucosa as the predisposing cause of the bronchopneumonia which is present in all cases coming to autopsy. The disease was common enough to be found in about three per cent of a series of necropsies at the Babies Hospital of New York.

There are now about one hundred cases reported with half proved by postmortem examination. The defective absorption of Vitamin A, suggested by Anderson, has been proved by Blackfan and May, and by others.

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.
From the Department of Pediatrics, Stanford University, School of Medicine.

A series of three cases is reported. The symptoms presented were chiefly those of early failure to gain on an adequate diet, with steatorrhea, and soon the symptoms of intermittent or chronic respiratory infection. These are the symptoms for which the patient is often brought first to the physician. The latter soon dominate the clinical picture. Sometimes, conjunctivitis is present. The child is underweight and there is abdominal distension. If the baby be premature the symptoms may be present very early as there is less Vitamin A stored in the tissues. In the diagnosis, the other diseases to be considered are lipoid pneumonia, coeliac disease, asthma, the chronic specific infections such as tuberculosis, syphilis, coccidiomycosis, and unresolved pneumococcus pneumonia or pertussis. The differential diagnosis is made more easy by careful and thorough histories, laboratory examinations, clinical tests, and roentgen studies. An enlarged thymus or foreign body is often suggested, at least by the parents, as a possibility.

The pathological conditions present are, first, a primary fibrotic or cystic pancreas, probably of congenital origin as suggested by associated congenital anomalies and a frequently elicited familial history. The pancreatic ducts may be open or in a state of atresia. Either small multiple abcesses, bronchiectasis, often more marked in the upper lobes, or chronic pneumonia, or combinations of these are present if the patient comes to autopsy. Osteoporosis may be present if the patient lives into the second year, perhaps dependent upon deficient calcium and Vitamin D absorption. True rickets is usually absent probably because of the slowness of growth.

The treatment consists of supplying pancreatic enzymes and large amounts of Vitamin A by mouth, supplemented by further large amounts of Vitamin A intramuscularly. Banana powder, containing large amounts of invert sugar, is most easily absorbed in the absence of deficiency of natural pancreatic juice. Supportive treatment is essential, and sulfathiazole may aid in keeping infection lessened. Avoidance of exposure to infection should be rigid. One patient has been recorded as having lived 14½ years. Anderson has diagnosed ten patients by examination of duodenal contents for pancreatic juice. Of these, seven have died. Three are alive and well, between eighteen and twenty-four months of age, are gaining well and have largely or entirely recovered from their respiratory infections. She states that the prognosis is uncertain, but suggests that with the proper treatment, they may lead fairly normal lives.

As the pathological changes in the respiratory mucous membrances may in part be irreversible, obviously the most important single item in the treatment is its early initiation. This is dependent on its early recognition, the burden of which lies with the pediatrician and the general practitioner.

Tuberculosis is a tremendous economic problem. Over $70,000,000 was spent last year on hospital care alone.

WHAT PATIENTS SHOULD BE TREATED AND BY WHAT METHOD?*

PAUL C. SAMSON, M. D.
Oakland

RATIONAL therapy is dependent on careful evaluation of both the tracheobronchial lesions and the subtending pulmonary tuberculosis. Fundamentals of bed rest and balanced high caloric diet must not be forgotten. Attention should be drawn to Bogen's report on the improvement of mucous membrane lesions following the ingestion of large amounts of vitamin C. It is recommended that this routine be followed as part of the general program. The use of general body radiation with ultra-violet light appears to have lost favor as a specific means of treating tracheobronchial lesions. There is the additional danger of exacerbation of the pulmonary tuberculosis.

DIFFUSE NONULCERATIVE NONSTENOTIC BRONCHIAL DISEASE

This type is characterized by congestion and edema of the mucosa, usually involving the orifice of the lobar bronchis and extending proximally in the stem bronchus. I suspect some of these lesions are non-specific. The majority are tuberculous however, proved by the later development of frank ulceration. Biopsy is contraindicated. Such lesions may well represent a type of allergic response in the mucosal and submucosal tissues. In general, no local treatment should be used. The pulmonary tuberculosis should be treated as indicated without regard to bronchial lesion.

FIBROSTENOSIS

The decision as to the employment of local treatment depends on whether or not symptoms are being produced by the stenosis. In the rare case of circumscribed stricture symptoms may be completely relieved by simple dilatation. More often, however, the stenosis is an irregular scar-tissue tunnel one or more centimeters in length, and dilatation is not effective. Kernan has had some success with copper bougies, using a negative galvanic current. In the presence of a stenosis the treatment of the pulmonary lesion must be carefully evaluated. In general, collapse pneumothorax does not yield good results. It is almost certain that complete and permanent atelectasis will follow, if there is any appreciable degree of stenosis. Fibrous stenosis is an irreversible process and we favor thoracoplasty whenever possible. If the patient has had trouble in expectorating prior to operation because of a stenosis, aspiration bronchoscopy has been employed routinely at the conclusion of surgery. In rare cases

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* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.
Panel Discussion.
From Alameda County Institutions.

where thoracoplasty is contraindicated it may be possible to use pneumothorax to help control a continuous harassing cough. Lobectomy, pneumonectomy or the external drainage of a tuberculous cavity may occasionally be necessitated because of high-grade bronchial stenosis, particularly: (1) If a technically adequate thoracoplasty has failed to control the tuberculosis; (2) if there are continued signs and symptoms of chronic pulmonary suppuration.

GRANULOULCERATIVE BRONCHIAL DISEASE

We concur in the majority opinion that lesions of this type should receive actual local treatment. In early lesions, especially those which do not involve the whole circumference of the stem bronchus, there is every evidence that local therapy reduces the incidence of high-grade stenosis. Myerson, alone, feels that local treatment is of no value and that all tuberculous tracheobronchial lesions heal spontaneously. We cannot agree with this view. No collapse therapy of any variety should be used in the presence of an active or advancing ulcerative tuberculous bronchitis. If the lesion is at all diffuse, the application of from 10 to 20 per cent silver nitrate is of definite benefit. Prior to silver nitrate application the writer has often removed obstructing masses of granulation tissue by means of curette or cup forceps without undesirable sequalae. The immediate application of a coagulating agent to the more vascular base prevents any spread. Localized areas of ulceration or granulomas are accurately treated with the high frequency cautery. Kernan has reported the satisfactory use of a small mercury vapor lamp, endoscopically applied. The aspiration of retained secretions and the shrinkage of contiguous edematous mucosa with equal parts of 10 per cent adrenalin and 1-1000 adrenalin solution is of value in promoting adequate drainage. Local treatment may be repeated at from 14 to 21-day intervals. In addition to local therapy we are convinced of the value of a carefully graded course of tuberculin therapy. One cannot affect the deep tuberculous infection of the submucosa by endoscopic coagulation. Clinically, tuberculin therapy seems to aid in the more certain healing of bronchial ulceration.

When it becomes evident that the local lesions are regressing, attention can be given to the pulmonary tuberculosis. Again, we do not favor the use of pneumothorax because of the almost certain total and permanent pulmonary collapse which ensues. Where no contraindication exists, a multiple-stage thoracoplasty is the collapse procedure of choice.

Ulcerostenosis presents the combined problem of obstruction and active infection. Active local therapy should be directed at the ulceration even though there will be an almost certain narrowing of the stricture. An increase in the stenosis does not present as much hazard as the continued presence of active ulceration.

WHAT PATIENTS SHOULD BE BRONCHOSCOPED?*

J. Lloyd Eaton, M. D.
Oakland

THERE seems little question that a tuberculous tracheo-bronchitis is a complication which makes the prognosis less favorable and complicates the treatment of pulmonary tuberculosis in general. Our own figures show that results from pneumothorax collapse are much less favorable.

To help clarify our own ideas as to the value of bronchoscopy in the type of tuberculous patients with which we are dealing, we did 219 bronchoscopies on 597 patients during the year ending July 1, 1941. Bronchoscopy was done on 71 patients with non-tuberculous lung conditions, but here we give a summary of conclusions and opinions on 148 bronchoscopies which were done on 93 patients with pulmonary tuberculosis.

The incidence of tracheo-bronchitis in our patients can only be estimated from this study. The group studied was heavily weighted with positive cases, as many of them were picked because of suggestive symptoms. The diagnosis was made if the patient showed symptoms of x-ray evidence of the disease, even though the bronchoscopic examination was negative, because we have all seen patients with typically blocked tension cavities but in whom bronchoscopy showed no evidence of the disease. Of the 93 patients studied, 54 had tracheo-bronchitis. These 54 patients are 11 per cent of all our patients. Estimating the number of positive cases among patients not bronchoscoped, from the percentage of positive cases found among the patients who were just routine bronchoscopies, gives an estimated incidence of 27 per cent. It seems safe to say that tuberculous tracheo-bronchitis is not a rare disease.

An analysis was made of the incidence of tracheo-bronchitis in relation to several factors. Considering its relation to the extent of the pulmonary pathology, we find that 62 per cent of the far-advanced cases had positive findings. Minimal and moderately advanced cases showed 46 per cent. When we compare the percentages of positive cases to the number of cases in each age group, we find no significant age differences. When we compare by sex we do find a significant difference. Females have a somewhat higher incidence than males. More females were examined in the young group and more positive cases were found there, while in males the same was true for the middle age group. However, in the middle age group (30-49 years), the positive findings were only half as frequent in males as in females. It is this marked difference in this age group which has weighted the totals to show a lower

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Abstract.
From Alameda County Institutions, Oakland, California.

percentage of tuberculous tracheo-bronchitis in males.

In analyzing our group for the value of symptoms and x-ray findings in the diagnosis of tuberculous tracheo-bronchitis, we used only the well-known symptoms and x-ray findings as described in the literature, and only those present before any collapse therapy was started. No single symptom stood out as being especially helpful and only 35 per cent definite symptoms. Positive findings were present in 67 per cent, shown by x-ray evidence. The two most valuable x-ray indications were atelectasis, and evidence of a partially obstructed cavity as shown by a round cavity which contained a fluid level at least part of the time or showed sudden changes in size. By using both symptoms and/or x-ray evidence, the diagnosis could be suspected in 81 per cent of our positive cases; these were the only findings in 22 per cent. On the other hand, 20½ per cent of the cases with no symptoms or x-ray evidence, were found to be positive by bronchoscopy. This percentage is probably high, as undoubtedly some of the cases included were picked for bronchoscopy because of certain symptoms or fluoroscopic evidence which were not recorded in the case histories. It would seem that symptoms and/or x-ray evidence are very helpful in making the diagnosis, but that, without bronchoscopy, a goodly number of cases will be missed. Without routine bronchoscopy, I do not know how to diagnose these cases before treatment has begun.

We have some evidence to show that missing such cases may not be particularly serious. Although admittedly the number of cases when broken down into such sub-groups is small, the majority showed relatively mild lesions of edema, congestion, or granularity of the mucosa, and these cases responded to ordinary pneumothorax collapse therapy in about the normal expectancy, although the courses tended to be stormy. The patients who were negative to bronchoscopy showed this same good response to treatment. On the other hand all but two of the 30 cases with bronchoscopic findings of the more advanced lesions, classified as tuberculoma, ulcerative lesions, or fibrostenosis, did show symptoms or x-ray evidence which would lead to a suspected diagnosis, and most of those in whom pneumothorax was tried responded unfavorably.

It would appear, then, that the bronchoscopic findings are of considerable importance in respect to treatment, and that the patients with symptoms and/or x-ray evidence of tracheo-bronchitis are the group in which bronchoscopy will be of the most value.

In 1912 tuberculosis killed one person every three and one-half minutes. Today, tuberculosis kills one person every eight and one-half minutes. Christmas Seal funds have helped in the saving of lives that these figures represent.

* * *

Early tuberculosis is readily amenable to treatment and recovery is easily possible.

ROUTINE CHEST FLUOROSCOPY GENERAL PRACTICE*

ALBERT C. DANIELS, M. D.
San Rafael

AS early as 1914, a tuberculosis case-finding survey of the Women's Garment Workers Union of New York City was made by physical examination method; 6 per cent of the male workers were found to have active disease. Similar surveys of various trade Unions were made in 1939 by Howard and his co-workers with a roentgenological technique which showed an incidence of 0.68 per cent.

Hahn reports an incidence of 8.3 per cent active disease discovered by x-ray in 1932 among the graduate nurses at Columbia University Hospital. Over a period of time from 1933 to 1940, the percentage dropped to 1.7 per cent. He also found that 0.9 per cent of medical students and 0.8 per cent of student nurses had active lesions when studied by x-ray.

Tice found an incidence of .13 per cent of active reinfection type in the children of Chicago of school age. He found 0.92 per cent of positive reactors to tuberculin to have significant lesions. The cost of about $450.00 for each active case discovered, did not justify the means, in his opinion. Hutchinson and Pope confirm this in their Massachusetts survey which showed an incidence of .05 per cent and .08 per cent for male and female school children respectively.

In a survey of people who had been exposed to active tuberculosis in the household, Beekwen reports an incidence of .83 per cent. Graham, in a survey of 800 cases of pregnant women, reports a 1 per cent incidence of active, clinically significant disease. Data is not complete on the exact incidence of cases found in the survey of the draft inductees in the United States Army, but preliminary figures show the incidence of active pulmonary tuberculosis to be 0.97 per cent. Thus it may be seen that the incidence of tuberculosis in the general population is about 1 per cent.

In the county where I serve very little has been done in adult case-finding. In May 1941, the San Rafael branch of the Pacific Telephone and Telegraph Company requested a fluoroscopic survey to be made of their traffic force because of the discovery of two active, open cases of pulmonary tuberculosis among their members. Seventy-nine women of varying ages were so examined, and three more active cases were discovered; all were of an early parenchymatous type with no cavitation or positive sputum being present. Diagnosis was made in each case on x-ray confirmation of the fluoroscopic findings.

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* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.

Abstract.

From Marin County and Ross Hospitals, San Rafael, California.

Copy of complete paper may be secured from California Tuberculosis Association.

With the result of this small survey in mind, I decided to fluoroscope or x-ray every patient entering my office no matter what the original complaint might be.

This was begun in October, 1941, and since that time 250 patients have been submitted to examination. The fluoroscope has been used chiefly because of its ready availability and its low cost of operation. X-rays were taken of all chests which showed suspicious lesions on the fluoroscopic examination, and further attempts at diagnosis were made on suspicious cases by studying sputum, sedimentation rate, and history.

Seven active cases of pulmonary tuberculosis were discovered in this group of 250 patients, or an incidence of 2.8 per cent. One of these was missed entirely by flouroscopic examination, and was picked up by the patient's local physician by means of an x-ray plate. A number of x-rays were taken for fluoroscopically suspicious lesions, which the roentgenogram proved to be non-tuberculous in nature. Such error is, of course, not vital, but it is important not to allow active cases to slip through undiagnosed.

This series of cases is as yet too small to justify breaking it down into groups of ages and complaints, or to draw conclusions as to percentages, but these seven active cases of tuberculosis were found in patients varying in age from 18 to 57. None of these cases gave a history of close contact with tuberculosis, and only one person suspected it. Four out of seven had positive sputum, while the other three had x-ray evidence of disease and increased sedimentation rates. In six of these seven cases, the chest was negative to ordinary physical examination, as interpreted by myself. In five cases there was no history that would have led me to suspect pulmonary disease.

In the seven previous years of general practice, I had discovered five active cases of pulmonary tuberculosis; an inquiry made of other doctors in general practice in this community indicates that they discover one or at the most two cases a year which they diagnose as active disease needing treatment. An inquiry addressed to the same physicians indicates that approximately 30 per cent of the general population consults some physician during the year for some complaint.

If we assume that the percentage of incidence of clinically significant tuberculosis is 1 per cent in the general population of Marin County, there are approximately 500 cases existing at the present time. If the present ratio of 2.8 per cent active cases found in a general practice should continue to hold good, then in the 15,000 patients who consult a doctor yearly, there should be about 400 cases of tuberculosis, or about four-fifths of the active disease in the community.

Here then is a fertile field for mass surveys. These people come to doctors because they feel they need medical aid. No problem of education or persuasion exists in getting proper chest examination, if the cost can be kept down. Contrast this with the efforts to get Union, industrial, and school groups educated to the point where a large proportion of their members will submit to examination, even though this examination is free. Thus it certainly seems that an effort should be made to survey this group of patients who are already seeking medical advice.

The means for doing routine chest examinations will vary, beginning doubtless with the use of the fluoroscope in the doctor's own office. Some further provision for x-rays of suspicious chests will need to be devised. The procedure will remove tuberculosis from the complete responsibility of the State and place it on the patient and his own physician, to the advantage of the patient in that his disease will be found early when prospect of cure is greater.

THE TREATMENT OF PULMONARY CAVITATION DUE TO COCCIDIOIDAL INFECTION *

WILLIAM A. WINN, M. D.
Springville

THE occurrence of pulmonary cavitation in association with primary coccidioidal infection has been described by Farness and Mills,[1] Carter,[2] Powers and Starks,[3] and Winn.[4] It is now evident that such cavitation is a part of, or residual to the pulmonary involvement produced by primary coccidioidomycosis. There should be no confusion with coccidioidal granuloma, which remains a relatively uncommon disease in which cavitation of this type is unusual.

During the acute pulmonary stage of primary coccidioidomycosis these cavities may appear and disappear in a comparatively short time. On the other hand, there is a marked tendency for them to persist, long after the acute pulmonary reaction has subsided, as residual, thin-walled, cyst-like structures.

These latent cavities continue to serve as reservoirs for the continued growth of the fungus, C. immitis, in its parasitic phase, manifested by the presence of endosporulating spherules within the sputum or contents of the gastric wash.

Coccidioidal cavities are usually solitary but may be multiple and occur in any area of the lungs. By flouroscopy alone they serve as easily identified landmarks of the previous primary coccidioidal infection. Their usual thin-walled, "burned-out" appearance, with little or no surrounding parenchymal reaction has been so characteristic that we venture a diagnosis of coccidioidal cavity based upon the roentgenographic appearance alone.

Confirmation of the diagnosis is arrived at in

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* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.

Abstract.

From Tulare-Kings Counties Joint Tuberculosis Hospital, Springville, California.

the following manner:

(1) A suggestive medical history of residency of several weeks or more within the San Joaquin Valley or other known endemic areas. The frequent occurrence of single or repeated hemoptyses (nine out of 17 cases). Repeated episodes of productive cough are common, associated with chest pain of pleuritic type. The occurrence of erythema nodosum or multiforme in the past history is unusual. A striking feature in most of these patients is the lack of severe constitutional symptoms. They usually appear quite well and come to the clinic only because of hemoptysis, frequent "colds," chest pain or because of a chance roentgenogram disclosing the pulmonary lesion.

(2) Intracutaneous tests are then made using 0.1 cc. of coccidioidin in dilutions of 1:10,000 down to 1:100 inclusive. The test is exactly the same as the Mantoux procedure and is interpreted by the same standards with the exception that the peak of the reaction occurs in 36 hours. Routine tuberculin tests are also done, using freshly prepared solutions of Old Tuberculin or Purified Derivative down to and including the 1:100 dilution or the second strength. Extreme care is used in keeping separate the syringes, needles and sterilizing pans used for tuberculin from those used for coccidioidin skin testing. All cavity cases react to coccidioidin by the intracutaneous test.

(3) Sputum is often scanty in amount and may only occur during periods of respiratory infection or "colds." The chronic production of mucoid sputum also occurs but the amount is usually small. When sputum production is not obvious one may resort to gastric lavage. During acute primary coccidioidal infection sputum is usually a constant feature early in the illness but often disappears entirely long before the pulmonary lesion has cleared. It has been possible to isolate C. immitis from the pulmonary secretions in all 17 of our cases through the kind coöperation of Dr. C. E. Smith and his assistants of the department of Public Health at the Stanford Medical School. In each instance they have been able to confirm their findings by cultural and animal studies.

(4) This laboratory has also carried out our serologic studies. By using coccidioidin as an antigen they were able to demonstrate circulating antibodies in 15 of the 17 cases. We have considerable confidence in this particular laboratory test, having never obtained a false positive reaction, although we have sent a goodly number of serums as controls from conditions other than coccidioidomycosis, including tuberculosis, pneumonia and various miscellaneous disorders.

Having confirmed the diagnosis and, having ruled out tuberculosis which may be closely simulated, one must proceed with conservatism in any treatment directed toward such cavitation. Coccidioidal cavitation is practically always to be considered a part of the primary infection, either accompanying or residual to it. Primary coccidioidomycosis is very easily arrested within the human body and only occasionally goes on to dissemination. The application of the rigid code of treatment used in dealing with pulmonary cavitation associated with tuberculous infection, is unnecessary. Persistent pulmonary hemorrhage or the occasional large cavity associated with constant production of spherule-laden sputum, may be indications for collapse measures. Pneumothorax has been used, with success, in two of our cases because of excessive bleeding. Another patient with a large thick-walled cavity who had two to three drams of positive sputum daily, has had pneumothorax for two years and still has spherules in his sputum although the cavity can no longer be visualized within the relaxed lung. In this particular case, however, we are now trying our best to re-expand the lung because of the continued existence of a fairly large complicating recurrent effusion. In two other cases that were given pneumothorax over periods of 2½ years and six months respectively, cavitation has remained open. Both cavities closed spontaneously after the lungs were re-expanded. The remaining 12 cases have received no collapse treatment and have been observed over periods of from four months to four years, under normal and unrestricted living and working conditions. Of these twelve, five have closed their cavities spontaneously and the remaining seven still retain their cavities with little change in the roentgenographic appearance and without evidence of dissemination.

A "hands-off" policy is indicated toward most coccidioidal cavitation, especially when characterized by the usual latent or thin-walled roentgenographic appearance. Conservative treatment is also indicated during the acute primary phase of the pulmonary infection when accompanied by cavity formation.

It is believed that residual pulmonary coccidioidal cavitation is only an infrequent manifestation of the primary coccidioidal infection. However, it is realized that, in an unknown but not insignificant number of cases, pulmonary cavitation must occur and disappear spontaneously. As yet, we have not seen either acute or chronic dissemination of disease in any of our cavity cases, most of which have been under observation for one or more years.

CONCLUSION

(1) The first step in the treatment of pulmonary coccidioidal cavitation is to differentiate the condition from tuberculosis.

(2) Bearing in mind the association of coccidioidal cavitation with the primary coccidioidal infection, conservative treatment is indicated.

(3) Persistent pulmonary hemorrhage or the occasional large cavity associated with continued production of spherule-laden sputum may be indications for simple collapse measures.

(4) From the standpoint of public health, it is not necessary to isolate the patient or separate him long from his usual mode of living or em-

ployment. The infection is not spread from person to person.

(5) Although primary coccidioidomycosis may occasionally become a progressive disease and acutely disseminate, or, through endogenous reinfection result in chronic dissemination (coccidioidal granuloma), we have not yet in our experience seen either type of spread result from the existence of untreated coccidioidal cavities, regardless of either continued sputum containing the fungus or hemorrhage.

(6) The above is based upon the follow-up observation of 17 cases of coccidioidal cavitation. Full confirmation of these conclusions must necessarily await the study of a larger series of cases.

NOTE: 47 lantern slides were used to illustrate this paper.

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DISAPPEARANCE OF THE TUBERCULIN REACTION IN CHILDREN UNDER TREATMENT FOR VARIOUS ALLERGIES*

F. M. POTTENGER, JR., M. D.
AND
F. M. POTTENGER, M. D.
Monrovia

IN primary tuberculous infection bacillary products escape into the blood stream and produce sensitization of body tissues to bacilli and bacillary proteins. Thereafter the tissues react with inflammation and exudation and other protective effects to each reinoculation of bacilli or bacillary protein (tuberculin).

The inflammatory reaction is termed "allergy," and as found in the skin is the basis of the tuberculin reaction. This is only one portion of a many-phased immunity mechanism. Allergic reactions are somewhat labile, varying under different conditions and at different times. When the tissues have developed a high grade of immunity sensitization decreases, and the allergic response becomes less marked.

In clinical tuberculosis the patient's ability to withstand larger and larger reinoculations with decreased local inflammatory reaction is a necessity if the patient is to live. It is necessary to understand this variation in allergy in order to interpret properly the tuberculin reaction.

The immunity is an exaggeration of normal physiologic activity. It has been generally believed that although the tuberculin reaction may differ in strength from time to time, it rarely disappears entirely. Should it disappear frequently under any given set of conditions, and should the patient at the same time maintain a satisfactory degree of health during or after its disappearance such conditions would have to be considered as probably favorable to the patient. Inasmuch as the tuberculin reaction also may disappear during the loss of immunity which occurs in an advancing disease preceding death, and under conditions of cachexia, we must understand its disappearance as being both a favorable and an unfavorable sign, according to the conditions under which its disappearance takes place.

A series of forty-two children, some of which suffered from asthma, eczema, and other allergies, and others from low energy and delayed development, is reported in which positive reactions to tuberculin became negative during the time they were being treated with a high protein, high fat, and low carbohydrate diet; regulated exercise; and a potent extract of adrenal cortex.

Since increased permeability of tissues is known to be a factor in allergy, and since there is evidence that a high state of nutrition decreased permeability and also that the adrenal cortex has the same effect, and since the ability of these patients to react to tuberculin was either lost or reduced at the same time they were being improved or relieved of their other allergies, we must conclude that the treatment produced changes in physiologic resistance which lowered the sensitization of the tissues, thus making them less prone to react to tuberculin.

Approximately 36,000 civilians were killed in air-raids in England from June, 1940, to April, 1941. During a comparable ten-month period tuberculosis took 51,000 lives in the United States. Christmas Seal funds are our "home defense" against tuberculosis.

More than three million men, women and children have died of tuberculosis in the United States during the last thirty years. Over two million more would have died during that time if the mortality rate of 30 years ago had continued to prevail.

Tuberculosis killed more Americans in 1940 than were killed in action, or died from wounds received in action, during the First World War. Christmas Seal funds are used to reduce the toll of lives taken by tuberculosis.

The United States is gradually being freed from tuberculosis. In 30 years the death rate has been cut by 75 per cent. Christmas Seals have helped to finance these victories.

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*Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.

Abstract.

From Pottenger Sanatorium, Monrovia, California.

PROGRAM FOR WAR *

BERNARD C. BRENNAN
Los Angeles

THE California Tuberculosis Association has been organized and has existed for the sole purpose of rendering the greatest good to the greatest number in the public health field.

Two things happened on the 7th of December, 1941, so far as the California association was concerned. In the first place, we immediately offered our services to the United States Public Health Service and to the state and local health agencies. In the second place, we presented an added appeal for funds from the public, urging their increased giving in the Christmas Seal Sale then being conducted. A study of the chart indicates that the Pearl Harbor incident caused a lowering of the return for a few days until the appeal was heard by the public. The chart then indicates an increase so that the resulting net returns show an increase in the neighborhood of thirty per cent for the entire State of California over the preceding year. This is a recognition of the confidence the public has in the California Tuberculosis Association. With the honor and privilege accorded us in this recognition goes a corresponding duty and responsibility. We must use this money for increased service to the people of the State.

This additional service can be rendered in many fields and four in particular.

Expansion in Health Education: Added personnel, new type of services, efforts to reach individuals who can add to the service being rendered public health agencies.

New Phases of Education: We could add such items as emphasis on nutrition, dental hygiene, and coöperation in the various other services rendered by the public health agencies.

Special Service to Armed Forces: In following up those who have been rejected because of health, and in contact with families of our armed forces.

In the Industrial Field: Taking on added responsibility in industry for their own problems. In this connection, attention should be called to the new agricultural conditions which may add to our tuberculosis load. Men not used to this type of work will be called into service by reason of the evacuation of enemy aliens made necessary. This relating of services to the vital necessities should not be overlooked.

In general, our men are fighting for the civilization built up over many generations. Part of that civilization is the service rendered by such voluntary organizations as our California Tuberculosis Association. It is our responsibility here at home to protect that portion of our civilization which is effected in the realm of our activities. In that way we can take care of our share paralleling the efforts of those at the front.

If we are to go back to the public and expect a continuance of their confidence in the form of increased giving in the forthcoming Christmas Seal Sale we must merit that confidence by the service rendered during the current year. Let us keep in mind the necessity of gearing our thinking, our programming, our services and activities to the greatest good for the greatest number in the light of the emergency created by the war condition.

* Read before the California Tuberculosis Association, Los Angeles, April 9, 1942.
From the Los Angeles County Tuberculosis Association.

TUBERCULOSIS PROBLEMS IN INDUSTRY *

W. P. SHEPARD, M. D.
San Francisco

IT IS the purpose of this paper to review the effects of war on tuberculosis; to study some of the contributing factors which may account for the increase of tuberculosis during war; and to point out the large responsibility shared by industry and the medical and public health professions for the prevention of this serious menace.

WAR AND TUBERCULOSIS

Lest some may think "it can't happen here," let us see what is happening in countries now at war. In Canada war's impact, although at some distance, has already been felt for nearly three years. Among the Industrial policyholders of the Metropolitan Life Insurance Company who number over one million in Canada and whose death rates have closely paralleled those of the general population, there was an increase of 18.7 per cent in death rate from all forms of tuberculosis in 1941 over 1940. Whether this is actually attributable to the effect of war cannot be proven at this time. Death rates for the first two months of the year are more favorable. Nevertheless, this is a significant increase among a population group showing consistent reductions for many years.

In England and Wales between 1939 and 1940 the tuberculosis death rate among the general population increased 13 per cent among males and seven per cent among females. In Scotland the increase was 14 per cent.

Statistics from Germany and the occupied countries are now unavailable, but Vichy France reports a sharp increase in tuberculosis, and there is good reason to believe Germany is showing an increase.

During the last war none of the belligerent countries escaped an increase in tuberculosis. Among German women the death rate increased 75 per cent between 1913 and 1918. In Brussels the death rate increased from 177 per 100,000 in 1914 to 390 in 1918. In Warsaw the rate in-

* Read before the California Tuberculosis Association, Los Angeles, April 10, 1942.
Assistant Secretary and Pacific Coast Welfare Director, Metropolitan Life Insurance Company, Clinical Professor of Public Health, Stanford University.

creased from 306 in 1913 to 840 in 1917; in Cracow, from 407 to 908. In Belgrade the tuberculosis death rate in 1918 was 1,400 per 100,000.

Even the neutral countries did not escape. In the Netherlands the 1918 rate was 50 per cent above 1914. In Switzerland the increase was six per cent between 1914 and 1917. In our own country, brief and relatively easy as our participation was, the original registration states showed an increase from 134.8 tuberculosis deaths per 100,000 in 1916 to 151.0 in 1918, an increase of five per cent.

There can be no doubt that war and tuberculosis go hand in hand. We cannot stem the tide of war now except by making every sacrifice necessary to attain victory in the shortest possible time. Can we stem the tide of tuberculosis meanwhile? Let us examine some of the causes.

CONTRIBUTING FACTORS

Among the factors contributing to increased tuberculosis deaths during war are the following:

Food Shortage—due to destruction, decreased production, or a decrease in "real wage."

Overcrowding—due to destruction of homes, housing shortage, dislocation of large population groups, or decrease in "real wage."

Inadequate Medical and Public Health Facilities—due to destruction or confiscation of sanatoria, inadequate support of health departments, diversion of medical personnel to combat services, or decrease in "real wage."

Demands for Increased Work—due to the necessity of enormous increase in production and shortage of man-power in industry.

We know that tuberculosis is an infectious disease whose spread and whose disabling effects are enhanced by poverty, fatigue, malnutrition, and inadequate medical and public health facilities. These bring about the attendant dangers of overcrowding, increased contacts, inadequate rest, lowered resistance, improper diet, missed cases. If the war imposes sacrifices so great as to make it impossible to avoid these dangers, then a rise in the tuberculosis death rate is inevitable.

But this is a land of plenty for all. The necessity of such extreme sacrifices now seems unlikely. Food shortage in the sense that there are insufficient articles to provide a well-balanced diet seems improbable. Overcrowding due to destruction of vast numbers of homes seems unlikely. Less adequate medical and public health facilities than we now have, need not occur if we are aware of the importance of preserving the health of civilians. "Real wage" will be preserved if we can maintain a wise national economy.

Our immediate danger so far as tuberculosis is concerned lies rather in our being unaware of certain health essentials which we might sacrifice thoughtlessly. Among these are the proper conditions under which the necessary increased work will take place. This is largely in the field of industry. In fact, assuming that production of food, proper housing, health facilities and the value of the "real wage" will not be destroyed, then one of our major efforts in the control of tuberculosis during the first years of the war will be in coöperation with industry.

WORKING CONDITIONS

By "industry" is meant the whole complex of industrial management, union as well as owner control. Working conditions are largely the responsibility of industry, aided by wise governmental supervision, and guided by skilled and available medical advice.

Bearing in mind that industry's problems are enormous, we must be prepared to give them sympathetic and effective help to avoid the dangers we know from experience will increase the tuberculosis death rate.

DANGERS TO BE AVOIDED

Dangers to be avoided in industry are:

Longer Work Hours. Individual capacity for sustained work, regardless of whether it is light or heavy labor, varies enormously. All individuals reach a point, however, beyond which they cannot continue working without detriment to health. The 40-hour week seems well within this limit, even for the least robust. It might even be increased some without harm, but to encourage or even permit men and women to work 10 hours a day 7 days a week is dangerous from the health standpoint. This danger is not mitigated by time-and-a-half or double-time pay. Except in the direst emergency, the length of work hours must be kept within health protective limits.

Inexperienced Help. It is an old observation among foremen that "the green hand sweats the most and does the least." War production will pull into industry many young people not accustomed to continued arduous employment. Many will be young girls. Many will come from rural areas without the immunity commonly attributed to city dwellers. They are the age and sex group in which tuberculosis is most prevalent. Others pulled into industry will be those hitherto resting comfortably on relief, many of whom had latent or quiescent tuberculosis which will be activated by going to work. These groups, until they become skilled or are medically classified will "sweat the most and do the least," be paid the least, be driven harder by the pressure for more production. They need close medical observation. Will they get it?

Lessened Health Safeguards. It is the rare factory that can change over from peace to war products, expand a thousand per cent, adapt itself to governmental regulations, speed up unit production, and still maintain its health safeguards for employees. Industrial medical programs are usually evolved over a period of years and are best developed in the older, better established industries. Many of these war industries are brand new from the top down. We have here all the makings of a vicious circle: inexperienced

employees of an age particularly susceptible to tuberculosis, new industries with undeveloped health safeguards, no provision for locating early cases of tuberculosis, increased contacts and more tuberculosis.

NECESSARY HEALTH SAFEGUARDS FOR INDUSTRY

Every physician or nurse given an opportunity to make recommendations to these industries should stress the importance of the following:

Pre-employment Examinations. These are necessary to avoid subjecting those with physical handicaps, including unrecognized tuberculosis, to work which will aggravate their condition. The examination should include special measures to detect tuberculosis.

Periodic Health Examinations. All employees should be examined annually. Those who require examination more frequently than once a year include: those in hazardous occupations and those whose behavior deviates from normal. The periodic health examination is still our best method of picking up early tuberculosis as well as other early physical handicaps which lead to more serious conditions if neglected. If the periodic examination includes an adequate chest examination, it is especially valuable.

Industry should be informed that local tuberculosis associations in this State can arrange through the California Tuberculosis Association to provide a portable fluoroscope and competent medical examiners for this purpose. Arrangements can also be made through the Industrial Hygiene Service, State Department of Health, to obtain the loan of fluoro-photographic outfits for taking small chest films. These outfits are loaned to states by the Bureau of Industrial Hygiene, United States Public Health Service, Washington, D. C.

Compliance with Well Established Standards for ventilation, illumination, sanitation, safety and freedom from toxic hazards. This may require close coöperation between the engineering and medical departments, and once established can only be maintained by constant inspection.

Dispensary and First Aid Rooms. A medical headquarters containing modest equipment for the treatment of minor ailments and for rendering first aid is essential. This soon becomes a medical headquarters where those with minor complaints and health problems may find sound medical and nursing advice readily available.

Employees' Health Education. Some plan of health education of employees including safety, nutrition, and personal hygiene is important. Proper nutrition is almost solely an educational problem. Our present prevalence of malnutrition is due to lack of education rather than scarcity of the components of a well-rounded diet.

Responsibility of Foremen. If industry is aware of health needs among employees and if effective work is to be done, the foremen are easily taught to keep a close watch on the people working directly under them and to refer to the Medical Department those who show abnormalities such as undue fatigue, loss of weight, nervousness, or manifest illness.

Health During Non-work Hours. Industry may legitimately interest itself in what happens to its employees during non-work hours. While it is true that the employer has no legal responsibilities once the employee leaves the plant, and most employers have no desire to be paternalistic, nevertheless it is also true that much absence due to illness originates in faulty personal or domestic hygiene and in many plants more lost-time injuries take place during off-hours than on the work premises. Men who drive 50 miles from home to job because of housing shortage near the plant or those whose only home is in their car or in a tent can hardly be expected to do their best work. These are not direct responsibilities of industry, but the employer's and the union's influence on the individual or on local housing and health authorities will often expedite remedies for situations which increase health hazards.

Plant Cafeterias. Well operated plant cafeterias serving a hot meal at cost or at company expense often go a long way toward correcting serious nutritional problems. Experience has shown that one well-balanced meal a day can be served economically and it pays dividends in improved health.

Rest Periods. Especially where the work is monotonous, rest periods, even though as short as five minutes and even though provided but twice a shift, will often increase production. Certainly they are an added safeguard to health.

Rotation on Night Shifts. Those who are to work on night shifts should be recruited from more experienced employees at first and rotated not less than every three months. Most workers become accustomed to night work in a short time, but their day sleep is shorter and lest restful. Youngsters are especially inclined to sacrifice rest for the pleasure of social activities.

Prevention of Silico-tuberculosis. Some industries, especially the newer and smaller ones, need to be reminded that finely divided silicon dioxide or silica inhaled by workers is a direct cause of tuberculosis and is compensable. There is no need for a "dust hysteria." Most dusts, fortunately, are well handled by the respiratory tract. So far as we know now, silica is the major tuberculosis hazard among all the dusts, fumes and gases. Lanza says, "It has been customary to associate a high incidence of tuberculosis with the dusty trades, but aside from exposure to silica, a casual relationship with reference to dust has been assumed rather than proven." Even this to be harmful must exist in finely divided form and must exceed 5,000,000 particles per cubic foot to be dangerous. It is important to review the wide range of industries in which exposure to silica may take place.

APPROACH TO INDUSTRY

These are the items of constructive advice we should be prepared to offer industry at each opportunity. One word of caution is necessary,

however, on our approach. It is of little avail to pound on the gates of industry shouting advice which comes from strangers who have little knowledge of industry's problems. To industry, production is of first concern and health is often secondary. When they do consider health, it is health as a whole, not as tuberculosis, venereal disease, or malnutrition. Most often their first health concern is with safety or with specific hazards arising from their processes, such as lead poisoning, silicosis, dermatitis.

The health problems of industry, including tuberculosis, are all covered in the rather highly specialized field of industrial hygiene, which is the application of public health methods to industry. The California State Department of Health has a well organized and efficiently operated Industrial Hygiene Service. It is well equipped and staffed with experts in medicine, chemistry, and engineering. It works closely with the Industrial Accident Commission and the Workmen's Compensation Board. It is being well received by industry throughout the State, has ready entree to industrial councils. In addition, several county and city health departments have well organized bureaus of industrial hygiene which work closely with the State. Unless some unusual opportunity occurs, it is usually better to approach industry through these official agencies, rather than to make a separate approach concerning tuberculosis alone. Industrial hygienists are as much concerned with the control of tuberculosis in industry as we are and will often welcome the facilities available through the local tuberculosis association.

SUMMARY

To summarize, war and tuberculosis go hand in hand. We are better prepared than ever before to attempt control of tuberculosis in this war. To do so will require increased effort and continued financial support. If victory requires such extreme sacrifices as large destruction of food supplies, homes and the value of the "real wage," and if it requires serious curtailment of adequate health facilities for civilians, then a great increase in tuberculosis is inevitable. Assuming that such extreme sacrifices can be avoided, then war tuberculosis can be largely controlled. One of our most important fields of endeavor must be in industry where many of the conditions originate which contribute to the rise of wartime tuberculosis.

The x-ray is one of the most important weapons this country has for civil defense.

"The battle against tuberculosis is not a doctor's affair, it belongs to the entire public," said the famous Sir William Osler.

One of the greatest achievements of the 20th century can be the eradication of tuberculosis in the United States.

ADMINISTRATION OF CASE FINDING IN INDUSTRY*

E. P. Von Allmen
Oakland

OF ALL the newly-reported cases of re-infection type tuberculosis in Alameda County last year, 89 per cent were over 20 years of age.

Since most of the people over the age of 20 will be found at work, it is important to tuberculosis control to try to find the people in the adult population who have tuberculosis and place them under treatment.

In the summer of 1939, it was decided by the Alameda County Tuberculosis Association to offer fluoroscopic chest examinations to people employed in industry. Our surveys to discover the proper place to begin were made of 24 adult groups, ranging in size from 100 to 1000 employees.

That suggests the way to start such a program is by choosing the logical groups. A part-time plant physician may be interested in a survey, if approached by the proper person. Or, the opportunity to serve may result from a letter in plain English to the key person in the firm, describing the *free* service which tuberculosis associations can offer.

Your health department can be asked to work with you. The Department can suggest plants in which it would be a good idea to have such service offered.

Put the personnel officer of your local industrial firms and the industrial nurse on your mailing list for your monthly news bulletin, so that they will know what you are doing.

Eventually the news will get around that your Association provides this service and requests will come to you. From here on it is a coöperative effort between your association and the industry.

The routine work has been carefully worked out and from this experience other associations may be helped in making plans for such a project.

PROCEDURE USED

In fluoroscopic surveys equipment is moved to the plant; a room is darkened for the survey and employees are routed in small groups to this room for examination.

RESULTS AND COSTS

In the recent fluoroscopic screening of 5,611 adult persons, 120 were considered for further study.

Of this number, 76 persons, or 1.4 per cent, required medical treatment for tuberculosis or other pathology found; and 27 of these persons had active pulmonary tuberculosis.

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* Read before the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract.
From the Alameda County Tuberculosis Association.
Copy of complete paper may be secured from California Tuberculosis Association.

The group of 78 patients for whom home care was considered satisfactory *medically,* was composed of those receiving pneumothorax in the Health Department chest clinics; those whose condition was more or less chronic, for whom no special institutional care was prescribed; and those whose condition was so far advanced, even to the terminal stage, that institutional care was not considered essential to benefit the patient.

The remaining 60, or *43.4 per cent,* with one exception, had reasons of a *social* nature for not accepting institutional care.

Another problem of the tuberculosis control program results from patients who leave institutions against medical advice. This is partially controlled during the infectious period by serving an isolation order on each infectious patient institutionalized. With the passing of the infectious period this order must be rescinded by the public health department, and the patient retained, if at all, by persuasion.

Reasons given by patients leaving the institution against medical advice included:

Fear that the wife or the husband at home is "stepping out" with someone else, and in order to prevent family disintegration the patient thinks it important to return home.

Fear that the adolescent daughter at home is not being properly "supervised," or that the adolescent boy at home is "getting into trouble."

Fear of accumulating institutional indebtedness in spite of assurance that he will not be pressed for payment until financially able.

Dissatisfaction with the food, housing, or general care offered in some institutions, accompanied with much resentment toward the Health Department for removing the patient from a home he believes far more satisfactory than the institution to which he was sent for purpose of "getting well."

In many instances the reasons given by the patient are based on his emotions which have been so agitated by his experience that intellect has been almost entirely submerged. There is a real need for a wider use of intelligent social treatment to prevent the development of these problem cases.

At this time when man-power is at a premium, it is our bounded responsibility to supplement modern case-finding endeavors, and excellent medical care, with a carefully planned and executed social treatment program.

"Education of the people, and through them of the state, is the first and greatest need in the prevention of tuberculosis," said Dr. Edward Livingston Trudeau, first president of the National Tuberculosis Association.

* * *

The tuberculosis germ has been the target of more clinical and biological research than any other microbe.

* * *

The health of a community can be bought with dollars and cents.

THE MEDICAL SOCIAL WORKER IN A TUBERCULOSIS ASSOCIATION*

E. P. Von Allmen
Oakland

THE Tuberculosis Associations can perform a valuable service to the community by having on the staff a full-time, well qualified medical social worker.

QUALIFICATIONS OF WORKER

This worker should be chosen with regard to maturity, poise, personality and training.

HER DUTIES

This worker's services should be freely available—to the private physicians of the community who wish her assistance in specific problems; and to any patient or individual who has a tuberculosis problem with which he needs help.

COOPERATION WITH PRIVATE PHYSICIANS

In our county there are 842 licensed physicians and surgeons. If I walk into the office of one of these men and he makes a diagnosis of tuberculosis in my case he has probably completed the immediate task before him. He will undoubtedly then recommend that I obtain sanatorium care.

The next move is up to me. But suppose I do not know where to go, how to go, how to pay for my care, what to do about my family while I'm in the sanatorium?

Obviously to answer all of these questions requires more time than the private physician concerned with my medical condition can give to these non-medical aspects of my case.

If, then, my doctor can call the office of the Tuberculosis Association, and refer me to a well qualified medical social worker who knows or can find the answers to my non-medical problems, he has been helped, I have been helped and the Tuberculosis Association has rendered us both a constructive service.

In Alameda County about 45 per cent of our cases are referred to us by private physicians. These physicians know the social worker personally, the program of the Association and what they may expect in the way of assistance from the Association.

The medical social worker is prepared by training and experience to act with the doctor as an interpreter to these troubled families, and to assist in the reorientation of the family group to the changes with which tuberculosis has confronted them. Specifically, she will find out what problems, financial, special or even psychological have been presented by the diagnosis to the family unit as represented by the doctor's patient, and it will test her skill to help the patient and family over

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* Read before the California Tuberculosis Association, Los Angeles, April 9, 1942.
Abstract.

From the Alameda County Tuberculosis Association, Oakland, California.

Copy of complete paper may be secured from California Tuberculosis Association.

Sixty-four, or 84 per cent of the 76 persons with pathology were referred to 36 different private physicians and 12 persons, or 16 per cent to clinics.

The total cost of the 5,611 examinations was $2368.18, or 42 cents per person.

The cost of discovering each of the 76 persons needing medical attention was $31.16; the cost of finding each case of active tuberculosis was $87.71.

REPORTS TO EMPLOYEES AND EMPLOYERS

Considerable care needs to be taken with regard to reports on these examinations. These are regarded as confidential and only the employee concerned is given the findings on his own examination.

This is usually the understanding with the employer at the start. If the employee has tuberculosis and refuses treatment, the matter is then in the hands of the City Health Department for adjustment.

THE PROBLEMS OF TUBERCULOSIS ARE SOCIAL AS WELL AS MEDICAL *

WILTON L. HALVERSON, M. D.
Los Angeles

SUPPORTED with the findings revealed through a study conducted in Los Angeles County, we have tried to demonstrate the need for medical social case work in the care of tuberculous patients.

The problems which face the tuberculous patient are social as well as medical. Tuberculosis implies long term medical care and disability, total or partial. Chronic illness affects a patient psychologically. It changes his financial and social circumstances. The news itself is frightening. More often than not he needs aid in removing obstacles that stand in the way of his accepting the doctor's recommendations for treatment. Too often he rationalizes to the effect that perhaps he does not have tuberculosis, and seeks verification of his wishful thinking through some other doctor, not always a doctor of medicine. Or, he decides he is not really sick enough to inconvenience his family economically as yet, and drags on.

If these people are worthy of the expense of diagnosis and appropriate medical care, involving long-term sanatorium care, they are also worth the expense of proper social care. This should include a consultation service and guidance if the patient wishes, from a well-trained medical social worker. If this is offered at the time the medical diagnosis is made, it will help to adjust difficult social situations during the waiting period for sanatorium care, and is likely to bring him to the sanatorium in a more hopeful mental attitude. Social care should run concurrently with medical care.

In the Los Angeles County Health Department, we have had since 1927 a small staff of medical social case workers for the purpose of helping patients with other problems arising out of their need for medical care. It is department policy to offer each patient the opportunity of an interview with a trained medical social case worker, at the time of a positive diagnosis for either tuberculosis or venereal disease.

The aim of the medical social worker in this first interview with the patient is to find out how the patient has accepted the diagnosis; what it will mean to himself and his family; whether he understands the examining physician's recommendations; whether he expects to carry through on the recommendations; whether he wishes help in developing a plan of care; whether care can be arranged through private medical practice, or whether it need be arranged through other community resources or through the services of the County Health Department. This application of medical social work skills at the point of medical diagnosis and recommendations for care, when the patient is faced with the reality of the problems created by the discovery of a potentially disabling communicable disease, is of value to the patient. It is equally as important to the administration of the public health program and to the future medical economics of the community which eventually pays the bill for the neglected chronic, disabling diseases.

Recently, the Los Angeles County Health Department completed a study of 162 patients who had a positive sputum as of June 30, 1940 and were residing at home. The objective was to understand why these patients were not under institutional care. Of the 162, about 83 per cent (134) were eligible under the provisions of the California Welfare and Institutions Code for county institutional care. Of the total, 24 or about 15 per cent had been recommended for, and were awaiting sanatorium placement; 138, or about 85 per cent, were not being recommended for institutional care. An analysis of the "reasons" why placement was not recommended by the attending physician at this time showed the following:

	Patients	Percentage
Available care at home considered satisfactory from a medical standpoint	78	56.6
Patient unwilling to leave family group	18	13.1
Ex-sanatorium patient, unable to adjust to institutional care	12	8.6
Patient fears recommended surgery and medical care for which he was referred to sanatorium	18	13.1
Patient unwilling to comply with the provisions of the California Welfare and Institutions Code	4	2.8
Patient unwilling to accept diagnosis of tuberculosis	6	4.4
Patient feels there is racial discrimination at the County Sanatorium	1	0.7
Reason not given	1	0.7
Total	138	100%

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*Read before the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract.
Health Officer, Los Angeles County.
Copy of complete paper may be secured from California Tuberculosis Association.

Prevention of rheumatic fever even though the causative organism and immunization possibilities are not yet known is our aim. General improvement in the standards of living would go far toward this accomplishment. The frequency and severity of heart damage would be greatly lessened by prompt diagnosis and adequate treatment. This requires more intense and more widespread education of the professions and of the public to a better understanding of the principles involved and the realization that here is a Public Health problem of major importance.

VOCATIONAL TRAINING FOR THE TUBERCULOUS*

JOSEPH O. STANTON
Los Angeles

A WELL-DEFINED rehabilitation plan for the tuberculous ends with vocational training and remunerative employment. It should begin the day the patient learns from his doctor that he has tuberculosis.

During the first weeks of illness, a broad rehabilitation plan, stressing mental hygiene, should be introduced. The patient should be made to realize that some day he will be expected to return to normal society and a job. After he has made some adjustment to sanatorium life, the patient should be given a selected reading plan, followed by educational courses to fit his needs. Under the influence of a well-developed counseling plan, the patient is spared the torment of an insecure future.

That he has an opportunity for counseling and training should be made known to the patient early in his sanatorium stay. When he goes out of the sanatorium, he need not be faced with the dreary round of hunting for and finding the wrong kind of work which will eventually lead him right back to the sick-bed.

The real problem of the training and counseling, however, must await word from the doctor as to the feasibility of such training. Patients are of two kinds, those whose ambition pushes them to making a move toward rehabilitation before they are physically able, and those who lack ambition and refuse all help, building up a pity-complex. Also, there are the persons who have definite ideas of what they want to do and who are mentally or emotionally unsuited to the job they choose. These adjustments must be made while the patient is in the sanatorium. Quite as many patients ask for too little, as those who ask too much. Oftentimes, the counseling service finds a person suited for a much higher grade job than he feels he can fill. Here is another adjustment to be worked on.

A great variety of training is provided so that with careful analysis of the patient and his abilities, he may be trained and prepared for any job for which he is suited. Basic education is provided as well as job training.

One difficulty facing tuberculous patients is that unlike other handicaps there is no time limit on his disability. Tuberculosis stubbornly refuses to be put on a time schedule. That causes various interruptions of his training, and here again a fine piece of adjustment work must be done to keep the patient interested and aware of his opportunity even though the course of his training is interrupted.

Recent reports on rehabilitated tuberculous patients have been made and the case histories are encouraging. The training and placing of these people in jobs is also proved as economical. The largest group of people surveyed was the group of 436 cases, surveyed by Harry D. Hicker, chief of the State Bureau of Rehabilitation. Trained for 134 different occupations, these clients were rehabilitated at an average cost of $105.05.

SOCIAL SERVICE IN A SANATORIUM*

SIDNEY MELINKOFF
Los Angeles

THERE is no need to justify the importance of a social service program. That matter is common knowledge. In this paper, we shall, rather, try to lay down a few rules as guide for the functioning of a social service program in a sanatorium.

The social service program has one objective, to get the patient back into the stream of life as a self-sufficient, productive member of society. The program must, therefore, consider the individual's background, social, economic, educational, occupational and avocational, as well as his native or acquired interest and abilities.

There are three phases to the social work program; case work and psychiatric case work services, vocational rehabilitation and job placement.

The case work program, as shown by surveys of such services, covers many things, anything in fact which touches the life of the individual and which may make his cure less speedy and his return to normal life less sure.

Recreation is an important part of the program. The patient must be kept as happy and as occupied as his condition warrants and as a safeguard for his emotional and physical recovery.

A well-equipped library is essential. Motion pictures and radio provide excellent media for entertainment.

The choosing of new occupations for those

* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.
From State Bureau of Rehabilitation.
Copy of complete paper may be secured from California Tuberculosis Association.

* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.
From Jewish Consumptive Relief Association, Los Angeles, California.
Copy of complete paper may be secured from California Tuberculosis Association.

these difficulties. She will recognize this situation with respect to the long range aspects involved, beginning first with diagnosis, extending through sanatorium care and then to the return home and the resumption of the former or a new occupation.

She knows the community resources and what may be expected of them; she knows approximately what to expect with reference to the patient's eventual return to his family and whether it may then be necessary to help the patient into an entirely new occupation or whether he may resume his former job. She knows about the other members of the family and she tries to make sure that those who have been exposed to infection are placed under periodic medical supervision.

COOPERATION WITH PATIENTS

Not all patients are referred by physicians. Many of them apply to the Tuberculosis Association under their own power and of their own volition. Some are referred by friends of other agencies.

Some of the problems presented are those of people who are caught in the "no man's land" which exists between the institutions for the care of the indigent and the facilities for private medical care. They are ineligible for the first and unable to pay the full price of the second. For these persons part pay arrangements can be made if the financial situation justifies.

Very often the matter presented by the person applying is just a downright tough individual problem which the person can talk out with a worker who has sense enough to listen quietly. When this has been done the worker may be able to tap the necessary resources which help the individual to iron out his own trouble.

In the cases of these office applicants there is often need for a vast amount of interpretation to people who fail to understand exactly the significance of the problems which they face. Within the proper scope of her duties, the medical social worker may make these interpretations.

WHAT TUBERCULOSIS WORKERS SHOULD KNOW ABOUT HEART DISEASE *

HOWARD F. WEST, M. D.
Los Angeles

ACCORDING to the National Health Survey of 1935-1936, the incidence of heart disease is five times that of tuberculosis. If those with potential heart disease, arteriosclerosis, and high blood pressure are included the incidence would be ten times that of tuberculosis. This group heads our national mortality lists and contributes heavily to acute and chronic illness.

Heart disease, like tuberculosis, may cause acute illness requiring varying periods of bed rest, constant supervision and nursing care; it may cause prolonged periods, perhaps many years of chronic disability, or it may act only as a limiting factor requiring adjustment to physical activities, working strains, and so forth. Also like tuberculosis there may be more or less complete recoveries from heart damage followed by long years of useful life.

Like tuberculosis, the social component of heart disease is a large one. With nearly seven and one-half million people involved or potentially involved it is actually enormous. The financial factors are almost staggering. Beginning with an estimated $250,000,000 loss in wages per year we must add the costs of medical, hospital, and nursing care. Psychological problems are almost as important as financial. These may lead to difficulty in adequate control and consequent relapses. Fear and apprehension may lead to unnecessary limitations and medical expense. The social worker finds her greatest usefulness within these two broad fields of the economic and psychologic aspects of the disease.

It is the important subdivision of rheumatic heart disease that furnishes the closest analogy to the problems of the tuberculosis worker.

Rheumatic heart disease accounts for approximately 25 per cent of all heart deaths. It accounts for 90 per cent of heart disease under 30 years of age. Like tuberculosis it results in maiming and death during the period of greatest social and economic usefulness. It is the chief and really the only serious manifestation of the infection known as rheumatic fever.

Rheumatic fever is an infectious disease. The causative agent has not been definitely identified though certain forms of the streptococcus and filtrable viruses have been under suspicion. There is considerable evidence that it may be transmitted from person to person through discharges from the upper respiratory tract. Multiple cases in families, localized epidemics and waves of rheumatic activity in cardiac hospitals are seen. Symptoms are sometimes so mild that in from 50 to 75 per cent of cases of rheumatic heart disease, they are not remembered. However practically all valvular heart disease in persons under thirty years of age is due to rheumatic fever. The original infection occurs most frequently in childhood. Instead of conferring an immunity it increases the individual's susceptibility to subsequent invasion. Approximately 80 per cent of children under ten years of age have subsequent attacks.

Early and continuous care can do much to protect and minimize heart damage in rheumatic fever. The long convalescent period requires intensive training of both child and parents in the proper psychologic approach both to the more acute phases of the illness and to subsequent degrees of disability. Avoidance of strain without undue invalidism should be the guiding principle.

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* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.

Abstract.

President, California Heart Association.

Copy of complete paper may be secured from California Tuberculosis Assn.

who cannot return to their former work, and the training for those positions, is an important part of sanatorium care.

School work must be arranged for those in need of it and this is provided through the sanatorium classes.

Medical supervision as well as a continued social service program after the patient leaves the sanatorium is one of the requisites.

Assistance to the family, to save the patient from worry, is vital.

From the time of admission to the departure of the patient and for as long after his dismissal as he needs such help, the social service program is a coöperative effort of doctors, nurses, social worker, teachers, and occupational directors.

TEACHING TEACHERS TO TEACH HEALTH*

JOHN L. C. GOFFIN, M. D.
Los Angeles

A MODERN school health education program is one in which the school assumes responsibility for healthy children, educated in healthful ways of living in a healthful school environment.

Teachers are the chief medium for health education of the child. In their efforts to educate the whole child, body, mind, and spirit, they are constantly balked by health problems. The teacher takes these problems to the school physician for adjustment. The school nurse aids the physician and the home in getting these health problems solved, and physician and nurse help train the teacher to prevent pupil maladjustments by sound health education.

In the modern school everybody has a hand in this program and agencies outside the school may play their part. Without community participation, no school health program can be fully successful.

Tuberculosis Association workers specialize in fighting the tubercle bacillus, but its allies—ignorance, quackery, poverty, overcrowding, poor sanitation, malnutrition, chronic infection, and alcoholism—must be conquered also. This fight takes the Tuberculosis Association into the field of school health education. These workers can help to strengthen the school health program and aid in the task of teaching teachers to teach health.

In participating effectively in the health program in schools, it is essential to know the local situation and the community health problems. When these problems are understood, it is essential to know what the schools of the community are doing to help solve them. This involves getting acquainted with the school personnel from the Superintendent down, especially the school health workers.

In offering to strengthen the school health education program a constructively helpful approach is essential rather than a negatively critical attitude or one which offers panaceas or overnight reorganization. The case-finding survey, if one has not been organized, offers an excellent opportunity to make a health education contribution. There are many other tools at your disposal: posters, talks, motion pictures, health education units, pamphlets, etc.

Probably the most effective effort is one in which the schools, the local health department and the local tuberculosis association join as a cooperative enterprise.

* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.
From Board of Education, Los Angeles.
Copy of complete paper may be secured from California Tuberculosis Association.

ORGANIZATION PROBLEMS*

DALRIE S. LICHTENSTIGER
Martinez

A SUMMARIZATION is given of the problems of a tuberculosis organization and suggests procedures. The question of what constitutes a "good" organization, how a volunteer organization may be made to run smoothly, who should make up the board of directors, how to organize and carry out a program, are all discussed.

The paper is essentially one for full-time association secretaries, but contains material which would be of help even to those associations which do not employ such secretaries.

The tuberculosis mortality rate is now approximately 47 per 100,000 of the population. In the early 1900's it was close to 200.

Thirty years ago tuberculosis was responsible for 11 out of every 100 deaths occurring in the United States. Today it is responsible for less than five out of every 100 deaths.

Today tuberculosis is responsible for the death of one individual every eight and one-half minutes. Thirty years ago deaths occurred at the rate of one every three and one-half minutes.

There are more than 90,000 beds for the treatment of tuberculosis in the United States.

There are estimated to be about 500,000 active cases of tuberculosis in the United States.

During the period from 1937 to 1940 tuberculosis killed more Americans than were killed in action, or died from wounds received in action, during all the wars the United States has fought since 1776. The menace of tuberculosis is steadily reduced each year by Christmas Seal funds.

China held its first Christmas Seal sale in 1938 in the midst of war with Japan and has continued to hold a seal sale each year.

* Read before the California Tuberculosis Association, Los Angeles, April 9, 1942.
Abstract.
From Contra Costa Public Health Association, Martinez, California.
Complete copy of paper may be secured from California Tuberculosis Association.

The Tuberculosis Organizations in America

Organized in 1904, the aims of the National Tuberculosis Association are: *To study tuberculosis in all its forms, spread knowledge as to its causes, treatment and prevention.* Carried on through 48 state organizations, 2000 local associations, 700 hospitals and sanatoria, 1000 tuberculosis clinics, 23,000 public health nurses, thousands of physicians, and many other volunteers, the work is financed by the annual sale of Christmas Seals, which in 1941 provided more than seven million dollars. (The 1942 Christmas Seal is designed by Dale Nichols, Tucson, Arizona. The Seals go on sale November 23.)

In 1889, when Dr. Hermann M. Biggs asked twenty-four of New York's leading physicians how they felt about having the Board of Health warn people against tuberculosis as infectious and preventable, and issue regulations for public protection, only two replied favoringly. Today, physicians in general practice, throughout the country are whole-heartedly coöperating in tuberculosis control work. In California they are a motivating power behind the work of the tuberculosis associations.

* * *

National Tuberculosis Association

1790 Broadway, New York City

Officers

J. Burns Amberson, Jr., M. D., New York, *President*
W. H. Morriss, M. D., Wallingford, Conn., *First Vice-President*
Mrs. F. G. Hodson, Atlanta, Ga., *Second Vice-President*
Franklin Delano Roosevelt and Thomas Parran, M. D., *Honorary Vice-Presidents*
Charles J. Hatfield, M. D., Philadelphia, *Secretary*
Collier Platt, New York, *Treasurer*
Kendall Emerson, M. D., New York, *Executive Director*

* * *

American Trudeau Society

(Clinical Section of National Tuberculosis Association)

Officers

Henry C. Sweany, M. D., Chicago, *President*
H. Frank Carman, M. D., Dallas, Texas, *Vice-President*
Julius L. Wilson, M. D., New Orleans, La., *Secretary-Treasurer*

* * *

California Tuberculosis Association

45 Second Street, San Francisco

Officers

Reginald H. Smart, M. D., Los Angeles, *President*
William P. Shepard, M. D., San Francisco, *Vice-President*
Mrs. William H. Hargis, Salinas, *Secretary*
Bernard C. Brennan, Los Angeles, *Treasurer*
Fontaine Johnson, Sacramento, *General Counsel*
William Ford Higby, *Executive Secretary*

Directors

E. P. Brown, San Bernardino
C. H. Howson, M. D., Los Angeles
Philip H. Pierson, M. D., San Francisco
John W. Popovich, Fresno
Sidney J. Shipman, M. D., San Francisco
R. H. Sundberg, M. D., San Diego
Harold G. Trimble, M. D., Oakland
Harry C. Warren, M. D., Belmont

* * *

California Trudeau Society

(Clinical Section of California Tuberculosis Association)

Officers

W. L. Rogers, M. D., San Francisco, *President*
Howard W. Bosworth, M. D., Los Angeles, *President-Elect.*
Cabot Brown, M. D., San Francisco, *Vice-President*
Emil Bogen, M. D., Olive View, *Secretary-Treasurer*

California Tuberculosis Association

A Federation of 62 Local Associations

Roster of Member Associations

Alameda County Tuberculosis and Health Association
121 East 11th Street, Oakland
Carlisle Crosby, President
E. P. Von Allmen, Executive Secretary

Alpine County Tuberculosis Association
Markleeville
Mrs. Eugenia Bruns, President

Amador County Tuberculosis Association
Jackson
Ralph McGee, President

Butte County Tuberculosis and Health Association
Biggs
Dr. Edwin S. Peeke, President

Calaveras County Tuberculosis Association
Murphys
Dr. Elliott P. Smart, President

Colusa County Tuberculosis Association
Colusa
Mrs. Jack Fiske, President

Contra Costa Public Health Association
Martinez
J. D. Keith, President
Miss Martha Smiley, Executive Secretary

Del Norte County Tuberculosis Association
Crescent City
Rev. Hugh Huddleson, President

El Dorado County Tuberculosis Association
Placerville
Dr. A. A. McKinnon, President

Fresno County Tuberculosis Association
Fresno
Dr. Clarmont P. Doane, President
Frank Harader, Executive Secretary

Glenn County Tuberculosis Association
Willows
A. D. Pieper, President

Humboldt County Tuberculosis Association
Eureka
Dr. Joseph Woolford, President
Mrs. Claude Morrow, Executive Secretary

Imperial County Tuberculosis and Health Association
El Centro
Paul W. Cook, President

Inyo County Tuberculosis Association
Lone Pine
Mrs. M. L. Harbach, President

Kern County Tuberculosis Association
1825 "H" Street
Bakersfield
O. R. Kamprath, President
Miss Constance Poss, Executive Secretary

Kings County Tuberculosis Association
Hanford
F. J. Bowden, President

Lake County Tuberculosis Association
Lakeport
W. Roland Hanson, President

Lassen County Tuberculosis Association
Susanville
Dr. J. W. Crever, President

Long Beach Tuberculosis Association
921 Pacific Avenue
Long Beach
E. E. Buffum, President
Miss Annis L. Fletcher, Executive Secretary

Los Angeles Tuberculosis and Health Association
1010 Transportation Building, 122 East 7th Street, Los Angeles
Dr. Howard W. Bosworth, President
James G. Stone, Executive Secretary

Los Angeles County Tuberculosis and Health Association
132 West First Street, Los Angeles
Bernard C. Brennan, President
Miss Josephine McCarty, Executive Secretary

Madera County Tuberculosis Association
Madera
Howard L. Rowe, President

Marin County Tuberculosis Association
San Rafael
Mrs. Herbert Chamberlain, President

Mariposa County Tuberculosis Association
Mariposa
Judge Andrew R. Schottky, President

Mendocino County Tuberculosis Association
Ukiah
Mrs. Mark Eglin, President

Merced County Tuberculosis Association
Merced
Hugh K. Landrum, President

Modoc County Tuberculosis Association
Alturas
Judge A. K. Wiley, President

Mono County Tuberculosis Association
Bridgeport
Arthur A. DeChambeau, President

Monterey County Tuberculosis Association
Salinas
Peter J. Ferrante, President
Miss Violet Eleazarian, Executive Secretary

Napa County Tuberculosis Association
Napa
Mrs. Edgar D. Wallace, President
Mrs. Jane Boggs, Executive Secretary

Nevada County Tuberculosis Association
Nevada City
John Mann, President

Orange County Tuberculosis and Health Association, Ltd.
112 West Fifth Street, Santa Ana
Mrs. Oliver Wickersham, President
Mrs. Edna H. Crawford, Executive Secretary

Pasadena Tuberculosis Association
245 South Lake Avenue, Pasadena
Mrs. H. Page Warden, President
Miss Alice R. Kratka, Executive Secretary

Placer County Tuberculosis Association
Auburn
Mrs. Pierre Goss, President

Plumas County Tuberculosis Association
Quincy
Frank McAuliffe, President

Riverside County Health and Tuberculosis Association
Riverside
Ernest G. Button, President
Mrs. Louise Phillips, Executive Secretary

Sacramento County Tuberculosis Association
1006 Seventh Street, Sacramento
Fontaine Johnson, President
Mrs. Estella S. Edson, Executive Secretary

San Benito County Tuberculosis Association
Hollister
Eleanor Nolan, President

San Bernardino County Tuberculosis Association
490 Court Street, San Bernardino
L. E. Mitchell, President
Stanley T. Boggess, Executive Secretary

Santa Barbara County Tuberculosis and Health Association
Court House, Santa Barbara
Frank J. McCoy, President
Graydon Dorsch, Executive Secretary

Santa Clara County Tuberculosis Association
409 Beans Building, San Jose
Dr. O. N. Andersen, President
Mrs. Ann Castellanos, Executive Secretary

San Francisco Tuberculosis Association
604 Mission Street, San Francisco
Easton G. Hecker, President
Paul Neiman, Executive Secretary

San Diego Tuberculosis Association
1266 Seventh Avenue, San Diego
Mrs. Francis H. Mead, President
Mrs. Elizabeth G. Cary, Executive Secretary

San Joaquin County Tuberculosis Fund
130 South American Street, Stockton
Mrs. Percy C. Cleghorn, President
Miss Bernice Frankenheimer, Executive Secretary

San Luis Obispo County Tuberculosis Association
411 16th Street, Paso Robles
Mrs. A. S. Young, President

San Mateo County Tuberculosis and Health Association
115 Ellsworth Avenue, San Mateo
Bradford M. Melvin, President
Mrs. Ruth Close, Executive Secretary

Santa Cruz County Tuberculosis and Health Association
21 Front Street, Santa Cruz
Peter Jansse, President
Mrs. B. B. Wilder, Executive Secretary

Shasta County Tuberculosis Association
Redding
C. C. Gerrard, Vice-President

Sierra County Tuberculosis Association
Downieville
Dr. C. C. Sutton, President

Siskiyou County Tuberculosis Association
Yreka
O. G. Steele, President

Solano County Tuberculosis Association
526 Carolina Street, Vallejo
Dr. Gordon J. Bunney, President
Mrs. Dairie Lichtenstiger, Executive Secretary

Sonoma County Tuberculosis Association
618 Fourth Street, Santa Rosa
Dr. C. M. Carlson, President
William M. Flaherty, Executive Secretary

South Pasadena Tuberculosis Association
1132 Mission Street, South Pasadena
Mrs. Joie Tunison, President

Stanislaus County Tuberculosis and Health Association
Turlock
C. F. Perrott, President

Sutter County Tuberculosis Association
Yuba City
A. A. McMullen, President

Tehama County Tuberculosis Association
Red Bluff
Bert Storm, President

Trinity County Tuberculosis Association
Weaverville
Dr. L. C. Moore, President

Tulare County Tuberculosis Association
Lindsay
Marc H. Iseman, President

Tuolumne County Tuberculosis Association
Sonora
Ben Johnson, President

Ventura County Tuberculosis Association
Santa Paula
Mrs. Roger Edwards, President

Yolo County Tuberculosis Association
Woodland
Mrs. D. W. McWilliam, President

Yuba County Tuberculosis Association
Marysville
Dr. J. W. Linstrum, President

(Continued from Page 18)

The method about to be described is simple, inexpensive and efficient; so simple, in fact, that the same idea must have occurred to others. But there are still those who occasionally find themselves in the embarrassing position of not having enough hands for the many tasks which arise during the course of an intravenous anesthetic, and it is for these that this suggestion is intended.

Four strips of adhesive are prepared before the anesthetic is begun; one strip about 2″ x 18″, and the other three about 1″ x 6″. The first strip firmly binds the patient's arm to the arm-board, and is placed over the wrist so that both flexion and rotary motion of the arm is impossible. After the initial injection is made, a second strip is placed over the hub of the needle to anchor it in place. The third strip is placed along the barrel and plunger of the syringe, to prevent blood from backing up into the solution. The syringe is then elevated, to produce the correct amount of angulation, and supported with a sponge, and the fourth strip of adhesive then binds the barrel of the syringe to the patient's arm.

In this way the syringe is bound firmly to the patient's arm, and the anesthetist can safely leave the syringe from time to time to regulate the patient's airway, administer oxygen if necessary, observe the vital signs and refill his own syringes. The adhesive strip running along the plunger of the syringe can be easily lifted and replaced for injections.

1401 So. Hope Street.

A Surgeon's Prayer in Wartime

God of Battle, grant that the wounded may swiftly arrive at their hospital haven, so that the safeguards of modern surgery may surround them, to the end that their pain is assuaged and their broken bodies are mended.

Grant me as a surgeon, gentle skill and intelligent foresight to bar the path to such sordid enemies as shock, hemorrhage and infection.

Give me plentifully of the blood of their non-combatant fellow man, so that their vital fluid may be replaced and thus make all the donor people realize that they, too, have given their life's blood in a noble cause.

Give me the instruments of my calling so that my work may be swift and accurate; but provide me with resourceful ingenuity so that I may do without bounteous supplies.

Strengthen my hand, endow me with valiant energy to go on through day and night; and keep my heart and brain attuned to duty and great opportunity.

Let me never forget that a life or a limb is in my keeping and do not let my judgment falter.

Enable me to give renewed courage and hope to the living and comfort to the dying.

Let me never forget that in the battles to be won, I too must play my part, to the glory of a great calling and as a follower of the Great Physician. Amen.

Christmas night, 1941.

John J. Moorhead, Col., M.C., in Hawaii M.J. 1:157 (January) 1942.

Diagnosis is to disease what harmony is to music: any discord is fatal.

When the proper technique is patiently pursued the diagnosis makes itself.

Without a correct diagnosis, therapy is blind and often harmful.

INDEX—MINUTES: C.M.A. HOUSE OF DELEGATES

Re: Pages 60 to 107

(Continued from front cover)

MINUTES: HOUSE OF DELEGATES—ANNUAL SESSION, 1942

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

WILLIAM R. MOLONY, SR., M.D.....President
KARL L. SCHAUPP, M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON.....Executive Secretary

EDITORIAL BOARD

Chairman of the Board:
Dwight L. Wilbur, San Francisco.

Executive Committee:
Dwight L. Wilbur, San Francisco, Chm.
Fred D. Heegler, Napa.
Albert J. Scholl, Los Angeles.
George W. Walker, Fresno.

Anesthesiology:
Charles F. McCuskey, Glendale.
H. R. Hathaway, San Francisco.

Dermatology and Syphilology:
H. J. Templeton, Oakland.
William H. Goeckerman, Los Angeles.

Eye, Ear, Nose and Throat:
Frederick C. Cordes, San Francisco.
L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

General Medicine:
Garnett Cheney, San Francisco.
George H. Houck, Los Angeles.
Mast Wolfson, Monterey.

General Surgery (including Orthopedics):
Frederick C. Bost, San Francisco.
Clarence J. Berne, Los Angeles.
Fred D. Heegler, Napa.

Industrial Medicine and Surgery:
John E. Kirkpatrick, Shasta Dam.
John D. Gillis, Los Angeles.

Plastic Surgery:
George W. Pierce, San Francisco.
William S. Kiskadden, Los Angeles.

Neuropsychiatry:
John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:
Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:
William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:
David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:
R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:
Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:
Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

† For complete roster of officers, see advertising pages 2, 4, and 6.

HOUSE OF DELEGATES: FIRST MEETING

Minutes of the Thirty-Ninth Annual Session of the House of Delegates of the California Medical Association

Held at Hotel Del Monte, Del Monte, California Monday, May 4, and Wednesday, May 6, 1942

First Meeting, Monday Evening, May 4, 1942, in Room E, Convention Pavilion, Hotel Del Monte

The first meeting of the House of Delegates of the California Medical Association, at the seventy-first annual session, held in Hotel Del Monte, Del Monte, California, was called to order at 8:30 p.m., Speaker Lowell S. Goin, presiding.

SPEAKER GOIN: The House will be in order. The first order of business is the temporary report of the Credentials Committee (Edmund P. Halley, of Stockton; William M. Miller, of Auburn; and Delbert B. Williams, of San Bernardino). The Chair recognizes the Chairman of that Committee, Doctor Halley of San Joaquin.

DOCTOR HALLEY: Mr. Speaker, the Committee begs to report that there are 104 delegates. I move that they be seated.

SPEAKER GOIN: It has been moved by the Chairman of the Committee, and seconded by Doctor Doughty, that these delegates be seated. All in favor say, "Aye"; contrary, "No." The motion is carried.

SPEAKER GOIN: Mr. Secretary, is there a quorum present?

SECRETARY KRESS: Mr. Speaker, a quorum is present.

SPEAKER GOIN: A quorum being present, and the provisions of the constitution and by-laws having been complied with, I declare this House of Delegates duly constituted and open for the transaction of such business as may come before it.

The first order of business is the announcement of the committees—the Reference Committees of the House. The Chair has appointed the following:

REFERENCE COMMITTEE No. 1: *The Committee on the Report of the Officers and Standing Committees:*
J. Norman O'Neill, of Los Angeles, Chairman.
William A. Keene, of San Mateo.
H. D. Hoffman, of Orange.

REFERENCE COMMITTEE No. 2: *The Committee on the Report of the Council, Secretary-Treasurer, and Executive Secretary:*
L. Henry Garland, of San Francisco, Chairman.
W. L. Garth, of San Diego.
Charles F. Greenwood, of Alameda.

REFERENCE COMMITTEE No 3: *The Committee on Resolutions and Amendments to the Constitution and the By-laws, and New and Miscellaneous Business:*
Dwight L. Wilbur, of San Francisco, Chairman.
Dwight Murray, of Napa County.
Donald G. Tollefson, of Los Angeles.

The next order of business is the address of the President, and I have the honor of presenting to you the President of this Association, Dr. Henry S. Rogers, of Petaluma.

Address of President Rogers

PRESIDENT ROGERS: Mr. Speaker and Members of the House of Delegates: This morning I made in my address a casual reference to some of the political trends that may affect you in the future. As you will recall in the President's message to Congress, he cited that there would be an increase in the payroll tax to provide for the disability unemployment insurance to workers. Also hospital benefits. Since that time, on an average of about every five days, there has been appearing in the financial sheets, the *Wall Street Journal* particularly, about four inches in a column that is almost identical, word for word with each issue that comes out; except one issue will be the Department of Labor, the next time the Treasury Department, and another time the Social Security Board. Then it starts all over again with the Department of Labor all calling for an increase in payroll tax for Social Security, disability and unemployment and hospital benefits. The report of the Social Security Board, released about a month ago to Congress, goes a little bit farther. It expresses a wish to Congress for a 1 per cent payroll deduction, and provides the same rate of pay for disability and unemployment insurance that is now paid for our unemployment insurance. In addition to this, hospitalization for sickness, and a bonus of $3.00 per day while the individual is confined to the hospital are suggested. This is an attempt at the first step towards governmental control of medical care. If this goes through and is accepted, then in another year, a year and a half, or two years, there would be another request preceded by months of newspaper bombardment for another payroll tax to provide medical care for all the workers.

Now the only way that I can see for the medical profession to combat this is by unity and solidarity in our medical societies, so that we can present a unified front to the politicians. California Physicians' Service has definitely shown us a lot the necessity of medical care for these groups of citizens, on a prepayment basis. As far as the public is concerned, the people must be sold to the plan; they don't ask for it. It isn't the public that is asking the government to step in to give them this health insurance; it is the social service workers, plus the politicians, who see in this an opportunity to get their hands on payroll deductions, so they can sit around in sumptuous offices and manage the plan. I am hoping tonight, in all your deliberations that you keep in mind the relationship that the medical profession owes to the general public—our place in life in this country. Let us hold together in one solid unit and continue as a strong California Medical Association. (Applause.)

SPEAKER GOIN: Thank you, Doctor Rogers. The report of the Council will now be given to you by its Chairman, Philip K. Gilman, Captain United States Navy.

* * *

Supplementary Report of Council

DOCTOR GILMAN: Mr. Speaker, in addition to the report of the Council printed in the *Pre-Convention Bulletin*, there are a few additions I wish to make.

New Item No. 1.—Regarding Alameda County Medical Association and California Physicians' Service:

WHEREAS, The Council of the Alameda County Medical Association has by resolution advised the members of said Association to resign as professional members of the California Physicians' Service; and

WHEREAS, The Council of the California Medical Association, at its meeting held May 3, 1942, duly resolved to present to the Alameda County Medical Association the following question: "Will the members of the Council of the Alameda County Medical Association on behalf of its membership for the benefit of medicine and for the good of the profession in California, subjugate their personal opinions to the opinion of the majority of their fellows of the California Medical Association and rescind the resolution above mentioned; now, therefore, be it

Resolved, That the answer of the Council of the Alameda County Medical Association to said questions may be deferred for a period of thirty days. And within that time the Alameda County Medical Association must submit a definite answer in writing to the foregoing questions submitted to it.

New Item No 2.—Regarding Unit Values in Medical Service Plans:

A Committee of the Council is studying the question of hospital costs, and it is believed that certain changes can be made which will result in raising the unit values of the California Physicians' Service.

SPEAKER GOIN: Thank you, Doctor Gilman. The report of the President will be referred to Reference Committee No. 1. The Council report will be referred to Committee No. 2.

OTHER REPORTS

The next report is a report of the *Trustees of the California Medical Association.*

DOCTOR GILMAN: The report has been printed in the Pre-Convention Bulletin, Mr. Speaker, and needs no further additions.

SPEAKER GOIN: The report is referred to Reference Committee No. 1. The next order of business is the report of the *Auditing Committee,* Doctor John Cline, Chairman.

DOCTOR CLINE: The report has been printed in the Pre-Convention Bulletin and there are no additions.

SPEAKER GOIN: This report will be referred to Reference Committee No. 1. The next will be a report of the *Secretary-Treasurer,* Doctor Kress.

SECRETARY KRESS: The report has been printed in the Pre-Convention Bulletin. No additional report.

SPEAKER GOIN: This will be referred to Reference Committee No. 2. The next is the report of the *Executive-Secretary,* Mr. John Hunton.

MR. HUNTON: No additional report.

SPEAKER GOIN: Referred to Reference Committee No. 2. Report of the Editor, Doctor Kress.

SECRETARY KRESS: No additional report.

SPEAKER GOIN: Referred to Reference Committee No. 1.

(Vice-Speaker Askey takes the chair.)

VICE-SPEAKER ASKEY: The next is a report of the Chairman of the *Department of Public Relations,* Doctor Donald Cass, Chairman.

DOCTOR CASS: No further report.

VICE-SPEAKER ASKEY: The report will be referred to Reference Committee No. 1. We will now hear a report from our General Counsel, Mr. Hartley F. Peart.

MR. PEART: The report of the *Legal Department* is printed in the Pre-Convention Bulletin, and I will not burden you with any of the matters that it contains. I do, however, desire to call your attention and briefly discuss some vital developments in the field of government which have crept upon us in the past few years and which, if not properly understood, may engulf the profession.*

* Mr. Peart's Report appears in this issue, as one of the General Articles. See page 112.

VICE-SPEAKER ASKEY: You have heard the report of our Counsel, Mr. Peart. This report will be referred to Reference Committee No. 1. The next order of business is taking up of the *Reports of our Standing and Special Committees.* All these reports have been published in our Pre-Convention Bulletin. As I call the names of the Chairmen of each committee he may report a supplementary report if he has one. . . .

NOTE. Chairmen or Members of the Standing and Special Committees listed below stated they desired to make no additions to their respective reports, as printed in the *Pre-Convention Bulletin.*

* * *

Reports of Standing Committees:

A. Standing Committees.

Executive Committee—Henry S. Rogers.
Committee on Associated Societies and Technical Groups—John V. Barrow.
Committee on Audits—John W. Cline.
Committee on Health and Public Instruction—John Ruddock.
Committee on History and Obituaries—Morton R. Gibbons, Sr.
Committee on Hospitals, Dispensaries, and Clinics—J. Norman O'Neill.
Committee on Industrial Practice—Donald Cass.
Committee on Medical Defense—Nelson Howard.
Committee on Medical Economics—Glenn Cushman.
Committee on Medical Education and Medical Institutions—Loren R. Chandler.
Committee on Membership and Organization—L. A. Alesen.
Committee on Postgraduate Activities—Dwight L. Wilbur.
Committee on Publications—A. A. Alexander (Deceased.)
Committee on Public Policy and Legislation—Dwight H. Murray.
Committee on Scientific Work—George H. Kress.
Committee on Public Relations—Donald Cass.
Cancer Commission—Otto Pflueger.

Reports of Special Committees:

B. Special Committees.

Committee on Payments for Medical Services—John W. Green.
Committee to Survey California Medical Association Legal Department—Philip K. Gilman.
Committee on Conference with California State Federation of Labor—John W. Cline.
Committee on Medical Services Rendered by Hospital Associations—Dewey R. Powell.
Committee on Pension Policy for Retired Employees—Edward N. Ewer.
Committee on Hospitalization Subsidy—John H. Shephard.
Committee on California Industrial Accident Commission Fee Schedules—Morton R. Gibbons, Sr.
Committee on Medical Preparedness—Harold A. Fletcher.

* * *

VICE-SPEAKER ASKEY: The report of the *Committee on Public Policy and Legislation,* Doctor Murray.

DOCTOR MURRAY: No further report, Mr. Chairman.

SPEAKER GOIN: I think that this House ought to hear Doctor Murray.

Report: Committee on Public Policy and Legislation

DOCTOR MURRAY: Members of the House of Delegates: If you were present this morning you heard some of the things I had to say with reference to some of the work that has been done. If you have time, or will have time, or care to read, look at the report in the Pre-Convention Bulletin. You will find there the happenings that have taken place since this time last year. First of all, it was the end of the legislation session last year. The session was a bit stormy. That is past history. You probably know all the things that happened. The bills we considered most important were enacted. There were one or two bills that we would like to have seen passed, that were not enacted. However, there were no proposed laws enacted that we considered destructive or dangerous. . . .

Now the thing that may come to us, is State Medicine. That is the thing you have been hearing about all day and the thing that you will be hearing about all during the sessions of this meeting. We were told at Sacramento, in 1939, in no indefinite terms that, if there was not some plan evolved by which the low-income citizens of the State of California could have medical care, if we didn't provide it, we could expect that somebody else would provide it for us, and that somebody else of course would be through a government-controlled affair. It was then that California Physicians' Service was brought into being, and that has answered our problem so far. Last year at the beginning of the legislature, our friends in the legislature told us, "If you don't do something about this, we will certainly not stand by you anymore." We were asked very definitely and very particularly about C.P.S., and we had to give the Legislators our word of honor, individually and collectively, and we had to tell them that it was the truth, because it was. We have given them our word of honor that we are going to see this thing through, and believe me, we can't stop in the middle of the stream. If we do, we are just sunk, and that's all there is to that. . . .

The Legislators never forget a promise that is made, and if ever you tell them one thing they will never forget it. We must keep our promise, and I hope nothing will be done to destroy the service and other value of California Physicians' Service. . . .

Now you may be expected to be called upon a good many times, even you may think we have called upon you a lot in the past. Well, you are going to be called on a lot more in the future. I wish to thank you all for the assistance you have given us. Remember, when you sent me up to Sacramento last year, I told you I thought I had never seen such a big pair of shoes as June Harris wore. Now I am asking, since you sent me up there, do not throw me down, do not throw your committee down. Help us and we shall try to help you. Thank you very much.

VICE-SPEAKER ASKEY: Doctor Murray says he wants to thank us. I think this House of Delegates owes a vote of thanks to Doctor Murray. (A rising vote of thanks was given Doctor Murray.)

VICE-SPEAKER ASKEY: You see, Doctor Murray, we do appreciate you. We are going to stand back of you. Doctor Murray's report will be referred to Reference Committee No. 1. The Committee on Scientific Work and Annual Session Programs, Doctor George H. Kress.

SECRETARY KRESS: No further report.

VICE-SPEAKER ASKEY: The next is the report of the *Committee on Medical Benevolence,* Doctor Axel Anderson, Chairman. Dr. Anderson is ill and unable to be here. Our President, Doctor Rogers, will say a word about this.

PRESIDENT ROGERS: Mr. Speaker, I think if Doctor Anderson were here this evening he would have a supplementary report to add to his printed report.

This morning, at the general session, Mrs. Harry Hund, the President of the Woman's Auxiliary, presented to this committee, or to the C.M.A. for this committee, the sum of $734.00 from the Woman's Auxiliary, to be applied to the Benevolence Fund. (Applause.)

SECRETARY KRESS: Mr. Speaker, Doctor Anderson has submitted a supplementary report.

VICE-SPEAKER ASKEY: If it is the wish of this House, the supplementary report will be included in the report. Hearing no objection, it is included and is referred with the rest of the report to Reference Committee No. 3.

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We have other special committees, the *Committee on Payment for Medical Services,* Doctor John W. Green, Chairman.

DOCTOR GREEN: Mr. Speaker, the report of this committee has been filed. Would you like to have a report made, Vice-Speaker Askey?

VICE-SPEAKER ASKEY: Has it been published, Doctor Green?

DOCTOR GREEN: No, it has not been published, but it has been filed.

VICE-SPEAKER ASKEY: Will you please read it?

Report: Committee on Payments for Medical Services

DOCTOR GREEN: The report of this committee was presented subsequent to the House of Delegates' Resolution No. 12 of the last session and there was considerable correspondence considering this. There were a lot of complaints throughout the State of low pay for medical services, particularly that part which applied to large practice, so this was given to our committee. I don't believe that I should read all the correspondence. . . .

The other members of the committee thought there were certain legal aspects to this whole problem, and in order to get an answer for it, that we should appeal to Legal Counsel Peart, which we did. We have here his reply. I hate to read this because I am not a lawyer, I get all tangled up when I even think about it. . . .

"Dear Doctor: Since I wrote my letter to you of October 6th, 1941, we have had an opportunity to further study your inquiry concerning a possible by-law amendment under which the membership in the Association would be forfeited by any member who rendered professional services for fees below the standard adopted by the Association. We are discussing each point which appears to be relevant separately:

First, Expulsion Procedure.

As you no doubt understand, a member of a component county medical society or the California Medical Association may not be expelled from membership because of any act or conduct on his part unless due process of law is followed. This means that any member against whom charges are made must be furnished a complete copy of the charges, must be given due notice, and be given a full opportunity to be heard, and must not be expelled or otherwise disciplined unless the evidence is produced at on open hearing establishing violation of some constitutional or by-law provision or some accepted rule of professional conduct. Of course, the disciplinary provisions contained in the present laws of the California Medical Association comply with the foregoing requirements and were prepared and adopted by the Association in order that proper rules of procedure may exist for any disciplinary proceeding. The method set forth in the Disciplinary Code, Chapter II of the by-laws, is the only method that may be followed.

Two, the Adoption of a Minimum Fee Schedule. As we understand it, your proposal that a minimum fee schedule be adopted, first, through a by-law provision; and that any member who renders service below such a fee schedule shall be liable to expulsion or other discipline. Normally, courts do not interfere with the internal affairs of any incorporated association or society. However, there are certain cases expressly holding that any by-laws or any other rule of any association or society which is arbitrary or unreasonable may not be enforced and may not be the basis for expulsion. We have only been able to find one case directly dealing with the by-law provision of a medical society under which fees were regulated. The case in question is "The People vs. Erie County Medical Society," where it was held that a rule of the Erie County Medical Society fixing the minimum fee was unreasonable and against public policy. In that case, a member of the Erie County Society was expelled on the grounds that he did not live up to the Fee Schedule, and upon other grounds. The court held that the society had no right to interfere with the relationship of the member and his patient to the extent of dictating the fee to be charged. The Erie County Medical Society case arose in New York and was decided many years ago. However, we have been unable to discover any recent case directly in the point.

There is one case recently arising in the State of Washington which, while not exactly at point, is of some help. The case is "Horder vs. the King County Medical Society" where it was held that a county society by-law forbidding members to participate in a closed staff clinic or group practice was held valid and enforcible. The Supreme Court of the State of Washington stated that in its opinion the motive of the county society in adopting the by-law amendment was immaterial—and even assuming a selfish motive—such fact did not justify judicial interference.

There are no California cases directly on this subject. In view of the New York case above discussed, it is our opinion that it would be very unwise for the Association to undertake and adopt and enforce a minimum Fee Schedule even though the general views expressed in the Washington case might be used as an argument to support such a by-law provision.

Three, Present Rules of Professional Conduct. This is quite important. The principles of medical ethics of the American Medical Association at the present time provide that a physician shall not engage in the type of practice which results in inadequate or incomplete medical care. The principles also forbid the physician to dispose of his services under conditions interferring with reasonable competition among and with the physicians of the community. (Principles of Medical Ethics, Article 6, Section 2.) It seems to us that the type of practice which you have in mind, more than likely violates the foregoing sections of the principles of medical ethics. If this is so, it is not necessary to have a new by-law provision as a disciplinary proceeding should be based upon the existing principles. If there are any further inquiries that I have not fully answered, please let me know."

The report of the Special C.M.A. Committee is this: An exchange of our ideas on this subject came through correspondence with Doctor Best, Doctor E. R. Moody, Doctor A. E. Anderson, Mr. Hartley F. Peart, and after reading the letter of Mr. Peart which is appended, concerning this practice and proposed amendments to the by-laws, we have to report that no amendment will be suggested; Mr. Peart having informed us that such could not lawfully be done. (Applause.)

VICE-SPEAKER ASKEY: Thank you, Doctor Green, the report of this committee will be referred to Reference

Committee No. 3. Another special committee is that of the *Committee to Survey the California Medical Association Legal Department,* Doctor Philip Gilman, Chairman.

Doctor Gilman: Mr. Speaker, Doctor Best was Chairman of this committee, and when he was sent overseas I was requested to take his place as Chairman of that committee. The report of this committee, which is the result of a considerable amount of work, has been filed and is ready for your action.

Vice-Speaker Askey: The report of this committee will be referred to Reference Commmittee No. 3. The *Committee on the Conference with the California State Federation of Labor,* Doctor John Cline, Chairman.

Report: Conference with California State Federation of Labor

Doctor Cline: Mr. President, Mr. Speaker, and Members of the House of Delegates: This is in the nature of a progress report and is not in its final form. The Committee came into being as a result of certain overtures made to the California Medical Association by the California Federation of Labor. They never reduced to writing a desire to meet with us, but communicated by way of one of the members of the California Medical Association, whose offices are next door to the California Federation offices in San Francisco. A minority meeting of the council was held along with certain other members of the Association, in the Association offices, and a discussion was held concerning the points that the California Federation wished to discuss. Their first desire was that the California Medical Association set up a panel of industrial surgeons. It was pointed out to their medical spokesman at that time that that was an impossible thing for us to do. We pointed out to them that every doctor licensed in the State of California was competent and legally able to perform any service in industrial medicine and surgery, and that industrial medicine and surgery differed in no degree except that someone else was responsible for the care of such patients from the ordinary practice of medicine and surgery, and that the only method that we could pursue would be to send out to all members of the California Medical Association a blank asking whether or not they wished to take care of industrial patients.

That seemed to be unacceptable to the representatives of the California Federation, and they proposed then that we endorse a program whereby the two universities in the South and the two in the North set up panels. We pointed out again that that was something they would have to take up with the universities and had nothing whatsoever to do with the California Medical Association. Following came a series of meetings, and a committee was appointed. This committee was to continue negotiations with the California Federation of Labor in an effort to ascertain just what the Federation wanted. The Secretary of the California Federation of Labor, Mr. Vandeleur, was represented in some of these meeting by his attorney, Mr. Jennigen. . . . The Federation desired what we have expressed in this House of Delegates in the past, but there were certain implications concerning which I think the C.M.A. House of Delegates should be informed. Namely, in the first instance, free choice of physician. Now that is a fixed principle as far as our Society is concerned. On the other hand, the implication which we were able to obtain from the representatives of the California Federation was that, in the event of free choice in the case of destruction of the current principle that the insurance company has a voice in the direction of patients, that they would then set up of their own motion, certain panels of individuals to whom the patients would be sent. Further inquiry into that revealed that their desire was two-fold. . . . So when we reached that juncture, negotiations became rather difficult and at that point, Doctor Murray, Chairman of the Legislative Committee and President Rogers, both of whom had much closer contact with the individuals involved, took over, and at the present moment they are continuing negotiations with the California Federation of Labor in the effort to obtain a program which will be mutually acceptable to the California Federation of Labor and to the California Medical Association; and one which, at any rate, we should not feel compelled to oppose should it reach the Legislature, and one that we would prefer to give our whole-hearted support to, and also which would abolish the abuses which are fairly legitimate. (Referred to Committee No. 3.)

Report: Committee on Medical Services Rendered by Hospital Associations

Next is the report of the *Committee on Medical Services Rendered by Hospital Associations,* Doctor Dewey Powell, Chairman.

Doctor Powell: Mr. Speaker, Members of the House: Your committee on Medical Services rendered by Hospital Associations makes the following report. We recommend that a statement of policy adopted by the Council of the California Medical Association on October 26, 1941, be reiterated at this time and officially adopted by this House. That report is summarized in the following paragraph:

"California Medical Association has consistently endorsed the principle of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give, and it never has given approval to any contracts which provide medical benefits or services as a part of hospital services. It does not object to the provisions of limited diagnostic medical services, such as x-ray and laboratory along with hospital benefits, provided that these are arranged for on some ethical and legal basis, such as reimbursement indemnification. The Committee further recommends that the Council of the Society use every effort to see that this policy is carried out by the hospital associations in this state, both in spirit and in letter."

Mr. Speaker, this report, carefully typed, along with other files, was reposing in a brown brief case. I stepped into the Copper Cup Room tonight and desiring not to be handicapped in reaching with either hand, I set it aside for a few moments and it disappeared. Now, I might give a lecture on the evils of drink, but I am much more interested in getting back the brief case. So if any of you hear of a brown case with the name "Powell" inscribed thereon, you will earn my everlasting gratitude by returning it.

Vice-Speaker Askey: This report, being an addendum, to the Council Report, will be referred to Reference Committee No. 2.

Report: Committee on Hospitalization Subsidy

The *Committee on Hospitalization Subsidy,* by John H. Shephard, Chairman. Doctor Shephard.

Doctor Shephard: We were very pleased when the House of Delegates appointed this Committee in 1941 to investigate this hospital subsidy, but we are unprepared to submit any comprehensive report at this time. Contact was made with the California Hospital Association which appointed a Committee to study this in con-

nection with your committee. The question of legality of the hospital subsidy has been given some study, but a final legal opinion has not been secured. It is possible that, before such a plan could be operated, some constitutional amendment would be required. Contact has been made with various Grange groups all showing deep interest in the subject. Various Senators and Assemblymen have been interviewed. While all seem to recognize the merit and justice of such a plan, they were opposed to any action which would require any new or shifting tax burdens at this time. On account of the increased wages, and the decreased unemployment which, during the past year, has had a favorable reflection on the physician's income, many doctors are less interested in any change of the ways and means for the payment of medical costs. Your Committee believes that now is the time to give careful study, not only to the question of hospitalization subsidy, but to all phases of medical economics, so that when the post-war depression comes, we may have plans to meet it, which will preserve the highest type of medical service for all the people. We should not imitate the Indian who, through warm and dry weather, needs no roof on his tepee, and when it is cold and rainy, he can't build one. Your Committee suggests that this or a similar Committee be allowed to continue the subject of hospitalization subsidy.

VICE-SPEAKER ASKEY: Thank you Doctor Shephard. This report will be referred to Reference Committee No. 3.

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The next report is from the *Committee on California Industrial Accident Commission Fee Schedule,* Doctor Morton S. Gibbons, Chairman.

Report: On Industrial Accident Commission Fee Schedule

DOCTOR MACDONALD: Your Committee met on several occasions to discuss the Fee Schedule and had some difficulty at arriving at a basis for it. However, they finally felt that the fee schedule should be increased 50 per cent for home office and hospital visits, and 25 per cent for hospital schedules that are in effect at the present time. That was taken up with the Council of the California Medical Association which agreed with it and this will be taken up with the Industrial Accident Commission. Doctor Gibbons sent this afternoon a supplementary report of the Committee on Industrial Accident Practice Fee Schedule. There are several points that should be considered in discussing augmentation of the Industrial Accident Fee Schedule. First, increasing minimum fees paid for medical and surgical services; second, the ability of the Industrial Accident Commission to enforce the payment of fees according to any schedule; third, attitude of the State Compensation Insurance Fund in ignoring the Industrial Accident Commission's schedule; fourth, the practice of certain physicians, individuals and groups in accepting fees lower than schedules; and fifth, the attempt of insurance companies to avoid the services of physicians who insist on payment of accounts equal to schedule. The Council of the California Medical Association has approved the report of the Special Committee. The State Commission agrees to meet a delegation of the California Medical Association, on a date to be arranged. The Commission sets fees in cases where the injured person has been treated by his own physician, and has not had the services of a physician supplied to him by employers or insurance companies. The Commission will consider fees and cases where the doctors and the injured join in a request to the Commission for an adjustment of fees. The Industrial Accident Commission does not exact adherence to the fees schedule by the insurance companies. The attitude of the State Compensation Fund has always been to pay the minimum fee, maintaining that as the maximum fee. Certain physicians have also been willing to work for a cut-rate, and will continue to do so even if the fee schedule is augmented unless some mechanism is devised to prevent it. Insurance companies have, in the past, severed contact with the physicians who have been importunate about their fees, and required them to live up to their schedule. . . . (Referred to Committee No. 3.)

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The next report will be from the *Committee on Medical Preparedness,* Dr. Fletcher, Chairman. Doctor Fletcher.

Report: Committee on Medical Preparedness

DOCTOR FLETCHER: The following is a report to date of the activities of the Committee on Medical Preparedness. Until the outbreak of the War on December 7, 1941, this Committee, under the chairmanship of Doctor Philip K. Gilman, had already completed a great amount of work. The work of completing the questionnaire which was sent out in 1940 to every doctor in the United States by the National Committee of Medical Preparedness of the American Medical Association had been successfully accomplished. The task of obtaining physicians for medical examinations, advisory boards for the Selective Service and the Field Board work had been carried out and was working smoothly. Regarding the Selective Service Board, there have been several changes in the method of examining inductees and registrants, and in this work the Committee has coöperated with the Selective Service to the fullest extent.

Following the outbreak of the War on December 7th, the question of Civilian Defense, here in California particularly, became one of great importance. There had been a great deal of work done in the target areas, but on a State level the work was confused and far behind where it should be. Doctor Bertram Brown, who is the Director of Public Health of the State of California was appointed by Governor Olsen to act as chairman of the State Sub-committee on Health of the Committee on health, welfare and consumer interest of the California State Council of Defense.

In January, Doctor Brown appointed to this Committee Doctor Charles Smythe of San Francisco, Doctor O. D. Hamlin of Oakland, and Doctor Harold Fletcher of San Francisco. Doctor Brown appointed a similar Committee in Los Angeles, and divided the work of the Committee between the Northern and Southern Divisions. The members of the Southern were Doctor Wallace Dodge, Doctor L. A. Alesen, and Doctor Elmer Dahl. The work of the two Committees have paralleled each other. We were able to obtain the appointment by Governor Olsen of three full-time officers, with a budget to cover salary and expenses. Mr. Thomas Clark was made chief emergency hospital officer for the State. Doctor Morton R. Gibbons of San Francisco was made chief emergency medical officer for the northern half of the State, and Doctor Charles Francis Sebastian, chief emergency medical officer for the southern part of the State. These three men are coördinating the work of Civilian Defense from a medical standpoint throughout the State. Doctor Brown is Chairman of the State Committee as a whole, and has put in a great deal of time; and through his efforts the work of this Committee has gone on smoothly.

California Procurement and Assignment Service

In January, your Chairman was appointed California State Chairman of the Procurement and Assignment Service for Physicians; and I feel that a brief report of the activities of this important department should be incorporated in the report of the Medical Preparedness Committee. The work of the Procurement and Assign-

ment Service has entirely superseded all work in Medical Preparedness. My appointmnt came about through the recommendation of the C.M.A. Executive Committee and the recommendation of Doctor Charles A. Dukes, who was at that time Chairman of the Ninth Corps Area of the Procurement and Assignment Services. As you remember, Doctor Dukes had been previously Chairman of the Ninth Corps Area of the Committee of Medical Preparedness. The State Committee of Medical Preparedness is composed of one doctor, one dentist, and one veterinarian. My instructions were to appoint such local Committees for the State of California as were necessary to cover the work of the Procurement and Assignment Services. In appointing these Committees I asked for the recommendations of the President and Secretary of each County Medical Society according to the groupings of the California Medical Association. I asked the President and Secretary of each component Society to give me able, well-balanced and, if possible, older men on their committees. In the case where counties were in concentrated localities and cities, I asked the President of a County Society to appoint its own subcommittee to carry on its work. In almost 100 per cent of the cases, various county medical societies have recommended for appointment very excellent men. I have recieved almost 100 per cent coöperation from the various local and county committees. The tasks given to these committees in some cases have been enormous. The amount of detailed work in making up county surveys and reporting on the availability or non-availability of doctors applying for service in the military forces, and the attempts and intelligent consideration and thought of these committees facing their various problems that arise can only partly be conceived by most men who have not come in contact with this work. There is a tremendous amount of responsibility involved in this work on the part of the County and Local Committees. In such a big undertaking there was bound to be confusion through lack of clear-cut instruction in the beginning. The Central Board in Washington grew from a small corner in another office to an office of their own, and then to a building of their own, and I now understand they are going to move to still, larger quarters. I want here to express personally my appreciation and thanks to every member of these Committees for the way they have assumed their responsibility, and the responsibilities of the medical profession in carrying out this great program. I have not considered myself as a State Committee, but I have considered myself only in the light of the Chairman of a State Committee composed of the Chairmen of the various County Society Committees. I am meeting, and have been meeting with practically all of the County Committees in the State, and gradually we have been able to clarify a great many confused policies and ideas. I wish to append to this report a list of these County Chairmen and again thank them for their wonderful coöperation.

Some of you may not realize that the Procurement and Assignment Service is not a part of the American Medical Association nor a part of the State Medical Association. It is definitely a Federal Agency under the Federal Security Agency and a department of the Office, Health, and Welfare Services; therefore the members of these Committees are not considering themselves as working as members of the California Medical Association or the Local County Societies, but a part of a definite Federal Agency. The reasons for this are obvious. The Agency was created and organized by the American Medical Association, and its structure was approved by the House of Delegates of the American Medical Association, and it was recommended to President Roosevelt that he create the Procurement and Assignment Services as it is set up. The appointments to the Central Board and right down through the Corps Areas of the State Chairman and County Societies are all made through the recommendation and coöperation of the State Medical Societies and County Societies. This tremendous job has been put in the hands of the medical profession, and they have assumed the responsibility of making it a success. If we do not succeed, there are all too many forces ready to put this purely medical problem in the hands of lay directors; thus taking out of the hands of members of the medical profession any opportunity of controlling their destiny.

I feel that every physician should read carefully the article from the Procurement and Assignment Services in the February 21, 1942 issue of the *Journal of American Medical Association*, and then continue to follow in succeeding issues the items regarding Procurement and Assignment. If one takes the time to study the reasons behind this agency, and does a little bit of intelligent thinking on it, one will see many reasons why it must succeed and not fail. (Applause.)

VICE-SPEAKER ASKEY: Thank you very much, Doctor Fletcher for this report. I will refer it to Reference Committee No. 3. This is the last report of the Standing and Special Committees, and at this time I will return the gavel to our Speaker, Dr. Goin.

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Amendments to the Constitution

SPEAKER GOIN: On your program you will note three Constitutional Amendments pending, actually there are four. All which were introduced at the last session of the House, have been printed twice, and laid upon the table of the House for one year. The program is in error by reason of a misprint. These amendments are about to be committed. To avoid any misunderstanding, the Chair is now going to rule that the Committee to which these amendments are referred has the power to make certain changes in their wording. On one occasion, we had a very serious debate in the House because a reference Committee made a small alteration to an amendment. The Chair, therefore, rules the Committee has power to make changes in the amendment, provided that the modification of the rule to be amended is not exceeded. That very formidable sounding phrase means this, that if there were a by-law or a constitutional provision providing that the President, Doctor Rogers, should receive a magnificent sum of $25 a year and a patriotic delegate named Pallette introduced an amendment to provide for a salary of $50 a year, and that amendment were referred to a Committee, the situation would be this. The mover of the amendment obviously didn't believe that $25 a year was enough. He obviously didn't believe that $50 a year or above $50 a year was desirable, so that $25 is the Constitutional limit already fixed and $50 is the limit fixed by the mover of the amendment. The Committee in that instance would have the power to recommend that the salary be made $26 or $49 but not $51 or $24. Within those limits, the Committee has the power to make changes in the amendments, and these amendments are now referred to Reference Committee No. 3.

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NEW BUSINESS: RESOLUTIONS

The House is now open for the introduction of new resolutions and new business. May I remind you, please, that the meeting is being recorded electrically, the Speaker knows many of your names, the machine doesn't know any of them. When you arise to introduce a resolution, will you please state your name and county. Are there no resolutions to be introduced, no new business? Doctor Ayres of Los Angeles County.

Re: Industrial Accident Code

DOCTOR SAMUEL AYRES, Los Angeles: Mr. Speaker, Members of the House of Delegates: As Chairman of the Legislative Committee of the Los Angeles County Medical Association, I wish to introduce the following resolution:

WHEREAS, A situation has developed in the field of compensation insurance practice in which abuses are regularly occurring regarding the compensability of certain cases; and

WHEREAS, These abuses are harmful to the interests of employees in some cases, of employers and insurance carriers in others, and of the medical profession in still others; and

WHEREAS, Certain State Medical Associations, such as the New York State Medical Association, have recently enacted amendments to the industrial accident code which have corrected these abuses to the satisfaction of all parties concerned; therefore, be it

Resolved, That the Legislative Committee of the California Medical Association be instructed to prepare or approve suitable amendments to the industrial accident code which will eliminate the aforementioned objectionable practices.

SPEAKER GOIN: This resolution will be referred to Reference Committee No. 3. Doctor Madeley of Solano County.

Re: Subversive Activities

DOCTOR MADELEY, Solano County: Mr. Speaker, as a delegate of Solano County, I wish to introduce the following resolution:

WHEREAS, The Members of the Medical Profession are, and have been since the formation of the Republic, loyal, patriotic citizens; and

WHEREAS, In times of peace and in time of war the members of our profession have devoted their energies, their material resources and, when occasion demanded, their lives for the protection of the lives and property of their fellow citizens and for the preservation of the American way of life; and

WHEREAS, There are within the State of California a number of medical men licensed to practice the healing art in the State of California who are so lost to a sense of decency, and so lacking in these honorable qualities which for all times have characterized the members of the medical profession, that they have been guilty of subversive activities and of giving aid and comfort to the enemies of the United States; and

WHEREAS, It is the opinion of the members of the House of Delegates here assembled that medical practitioners guilty of such unethical and vile practices should no longer be allowed to legally practice the healing art; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association, in convention duly assembled, does hereby instruct the members of the Committee on Public Policy and Legislation, and the General Counsel of the Association to consult with the members of the Board of Medical Examiners and such other bodies as they deem wise, to the end that enabling legislation be introduced at the next session of the California Legislature which will make such practice of subversive activities, and the giving of aid and comfort to the enemies of the United States of America, cause for the revocation of the license to practice held by those guilty of such unAmerican and unethical activities. (Applause.)

SPEAKER GOIN: This resolution will be referred to Reference Committee No. 3. Doctor Russell Fletcher of San Francisco.

Re: Relation of State Association and Component County Units

DOCTOR RUSSELL FLETCHER, San Francisco: I wish to introduce this resolution:

WHEREAS, The unity of the medical profession is paramount in the interests of each individual practitioner, each component county society and, indeed, in the welfare of each individual in the State; and

WHEREAS, It is customary in all democratic organizations to be guided by the majority vote of duly elected representatives, and to abide by that vote until a majority decides to rescind or amend it; and

WHEREAS, The House of Delegates of the California Medical Association represents all of the doctors who are members of organized medicine in this State; now, therefore, be it

Resolved, That the members of this House reaffirm their belief in the principles of Democracy, and therefore agree to abide by the decisions of the majority in all matters acted upon by this House; and be it further

Resolved, That, in medical affairs State-wide in scope, the actions of this House of Delegates, binding as they are on all delegates, the individual members of the Association, shall equally be binding on all component county society units of the Association. (Applause.)

SPEAKER GOIN: Referred to Reference Committee No. 3. Doctor L. H. Garland of San Francisco.

Re: Relations between Physicians and Insurance Companies

DOCTOR L. H. GARLAND, San Francisco: This resolution is introduced from the San Francisco delegation. It concerns improvement of relations between physicians and insurance companies.

WHEREAS, It is desirable that physicians and insurance companies coöperate to the fullest extent, especially in the interest of persons covered by health and accident insurance; and

WHEREAS, A serious situation has arisen in the administration of certain health and hospitalization schemes whereby medical services are being billed under the term "hospital services," and are being paid for by insurance companies *only so long* as they are labeled hospital services; and

WHEREAS, The continuation or extension of such practices will inevitably lead to the inclusion of any type of medical service under the label "hospital service," at the convenience of the corporations involved, and to the detriment of medical care; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association hereby requests insurance companies to coöperate with the organized medical profession to the end that hospitalization policies shall include only hospital benefits. If the inclusion of indemnification for medical service (such as surgery or radiology) is desired, then payment of such shall only be made on receipt of certified statement from a physician that he has rendered such. Fees for medical services should be paid to physicians (via indemnity to the assured, or by check payable jointly to assured and physician). This practice should be maintained irrespective of whether a hospital chooses to bill for medical services as a part of its hospital bill; and be it further

Resolved, That the House of Delegates of the California Medical Association requests hospitals and physicians to coöperate with it in this important step, by seeing that bills for hospital and medical services are clearly distinguished; the latter should bear the name of the physician rendering the service to indicate clearly that the change is for medical service.

SPEAKER GOIN: Referred to Reference Committee No. 3. Further resolutions? Wilbur Bailey of Los Angeles.

Re: Rebates

WILBUR BAILEY, Los Angeles:

WHEREAS, The Principles of Ethics of the American Medical Association in Chapter III, Article 13, Section I, state that "The obligation assumed by a physician on entering the profession . . . demands that he use every means to uphold the dignity and honor of his vocation and to exalt its standards"; and

WHEREAS, Section 5 of the same Chapter states: "It is unprofessional to receive remuneration from patients on surgical instruments or medicine; to accept rebates on prescriptions or surgical appliances, or perquisites from attendants who aid in the care of patients; and

WHEREAS, Article VI, Section 3, of this Chapter states: "When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or receive a commission by whatever term it may be called or by any guise or pretext whatsoever; and

WHEREAS, Section 4 of this same Article states: "It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or

however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy; and

WHEREAS, Recent articles in magazines of wide national circulation have called attention to shady practices of secret rebates to physicians; and

WHEREAS, Commercial concerns and laboratories, by the employment of cappers and steerers, and by secret rebating are largely responsible for these criticisms; and

WHEREAS, The Better Business Bureau has complained of practices in which secret rebates were offered or accepted by physicians; and

WHEREAS, The dishonest acts of a few may be reflected to the discredit of the many; now, therefore, be it

Resolved, That it be declared unethical for the members of the California Medical Association or its component branches to refer patients to commercial organizations, laboratories, or other physicians who advertise, employ steerers of cappers, offer or pay rebates or commissions or in any other manner violate the Code of Ethics of the American Medical Association and its component branches. (Applause.)

SPEAKER GOIN: Referred to Reference Committee No. 3. Are there any further resolutions to come before the House?

* * *

Re: Physicians' Benevolence Committee

SECRETARY KRESS: Mr. Speaker, Doctor Anderson of the Council of the California Medical Association, who is ill, has sent word that Doctor Young, of his district, will present some proposed amendments.

SPEAKER GOIN: Doctor J. E. Young of Fresno.

DOCTOR YOUNG, Fresno: Amendments to the by-laws of the California Medical Association, amending Section 23 of Chapter 5 of said by-laws.

Resolved, That Section 23 of Chapter 5 of the by-laws of the California Medical Association be amended by deleting from the title of said Section, the words "Committee on Aid to Needy Members" and substituting "Physicians' Benevolence Committee," by deleting from said Section the words, "Special Fund for Aid to Needy Members," and substituting "Physicians' Benevolence Fund." By adding to said Section after the last paragraph thereof, the following sentence: "The Executive Secretary of the Association shall act as Secretary of the Committee."

And by adding to said Section 23 at the end of the sentence which is preceded by the designation (a), the following clause, "Provided, however, that the Council must in each year allocate to, and place in the Physicians' Benevolence Fund, a sum equal to $1 per active member of the Association, and to carry out the foregoing allocation, there shall be deposited in the Physicians' Benevolence Fund the sum of $1 out of each payment of annual dues received from each active member."

So that hereafter said Section 23 of Chapter 5 will read as follows: "Section 23: Physicians' Benevolence Committee. The Physicians' Benevolence Committee shall consist of three members whose appointments and terms of office shall be as provided in Section 2 of this Chapter. The Committee shall be responsible to the Council and the House of Delegates for all of its activities. The Committee shall administer those funds of this Association hereinafter designated as comprising the Physicians' Benevolence Fund. The Committee's administration of said Fund shall be subject to the provisions of this Section. The Funds which may from time to time be allocated to it from the general funds of the Association by the Council are the funds for this Committee, provided, however, that the Council must in each year allocate to, and place in the Physicians' Benevolence Fund, a sum equal to $1 per each active member of the Association; and to carry out the foregoing allocation, there shall be deposited in the Physicians' Benevolence Fund the sum of $1 out of each payment of annual dues received from each active member."

(b) "All requests, voluntary contributions and donations from any source whatever, that may be received by this Association for the express and implied purpose of aiding needy members or their dependents; and

(c) "All other funds from whatever source derived, except Accounts Receivable, payments for indebtedness to this Association, dues and assessments received by this Association where the payer, donor, or other persons transferring the funds express the intent that such funds shall be for aid to needy members. Funds contained in the Physicians' Benevolence Fund may from time to time be dispersed by the Physicians' Benevolence Committee. The Executive Secretary of the Association shall act as Secretary of the Committee." (Applause.)

DOCTOR YOUNG, Fresno: Herewith, also a proposed amendment to the Constitution of the California Medical Association, Article XI, Section I:

Resolved, That Section 1 of Article XI of the Constitution of this Association, California Medical Association (b) and the same hereby is amended by adding to said Section at the end thereof, the following paragraph: "At least $1 out of the annual dues paid by each member of the Association shall be allocated to the Physicians' Benevolence Fund and shall only be used for the purposes as set forth in the by-laws."

SPEAKER GOIN: We have here two matters:

The Constitutional Amendment that applies to Article XV of the constitution will lie upon the table of the House for one year.

As to the Amendment of the by-laws, in case any of you think you are undergoing an individual experience, please allow the Chair to assure you that you are no more bewildered than the Chair is with this page of legal phraseology. I have found by inquiring this afternoon that the intent is to add this to the by-laws. We thought at first we would have to add the by-laws to this. I would like to ask Mr. Peart to explain to us in words of one syllable just what this means.

MR. PEART: It is Doctor Anderson's purpose to allocate $1.00 out of the dues of each active member for this fund in the name of the Committee, and to put the handling of these funds entirely in the hands of this Committee without power to the Council.

SPEAKER GOIN: Rather than in the hands of the Council? This by-law may be adopted at the next session of the House of Delegates. It will be reported to Reference Committee No. 3.

* * *

Are there any further resolutions? If there are not, the Chair will remind you that tomorrow the Reference Committees will hear your objections to or arguments in support of any matters brought up tonight. That each one of you and any member of the Association has not only the right, but also the absolute duty to appear before these Committees to make known your views on these various matters.

If the Committee Chairmen, before leaving the room, will come to the Secretary's desk, each will then be presented with a folio containing the matters referred to his respective Committee. The Committee Chairmen are:

J. Norman O'Neill, Chairman of *Reference Committee No. 1,* which is the *Committee on the Reports of Officers and Standing Committees.* His Committee will meet tomorrow in the Billiard Room. Reference Committee will meet at 10 o'clock tomorrow morning in the Billiard Room.

Reference Committee No. 2 of which Doctor L. Henry Garland is Chairman. This *Committee on the Reports of the Council and Secretary-Treasurer* will meet in the Game Room which is on the ground floor opposite the elevator. This Committee will meet at 8 o'clock tomorrow morning.

Reference Committee No. 3 to which all other matter have been committed, Doctor Dwight Wilbur, Chairman, will meet in the Board of Directors' Room on the mezzanine floor at 9 a.m. I dare say that it will be in session until 6 o'clock Wednesday evening, continuously, so you better get around early because they may be in trouble before that.

SPEAKER GOIN: The minutes of the House have been recorded electrically. The Chair will entertain a motion to approve the minutes.

DOCTOR JOHN CLINE: I so move.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Moved by Cline and seconded by Doughty of San Joaquin. All in favor say, "Aye," contary, "No." The motion is carried. The Chair will now entertain a motion to adjourn.

DOCTOR JOHN CLINE: I so move.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: The meeting is adjourned. The House will meet in this room tomorrow and not in the Bali Room, Wednesday at 5 o'clock. Incidentally, I think these are the nicest quarters ever provided for the House of Delegates meetings, and I think I voice the sentiment of the House when I say we thank the Hotel Del Monte management and Del Monte Properties Corporation, for bringing into realization this new Convention Pavilion, constructed in good part, according to sketches submitted by the chairman of the C.M.A. Committee on Scientific Work. Next meeting of the House of Delegates at 5 p.m., on Wednesday, in this same room. Please be prompt.

First meeting of the House of Delegates, at the 71st Annual Session, adjourned at 10:30 p.m., on Monday, May 4, 1942.

HOUSE OF DELEGATES: SECOND MEETING

Minutes of the Thirty-Ninth Annual Session of the House of Delegates of the California Medical Association.

Held at Hotel Del Monte, Del Monte, California, Monday, May 4, and Wednesday, May 6, 1942

Second Meeting, Wednesday Evening, May 6, 1942, in Room E, Convention Pavilion, Hotel Del Monte

The second meeting of the House of Delegates of the California Medical Association in their seventy-first annual session, held in the Hotel Del Monte, Del Monte, California, was called to order at 5:10 p.m., Speaker Lowell S. Goin presiding.

SPEAKER GOIN: Will the House be in order please? For the purpose of receiving a supplementary report of the Committee on Credentials, the Chair recognizes its Chairman, Doctor Halley. Doctor Halley.

DOCTOR HALLEY: Mr. Speaker, your Committee on Credentials reports a total of 78 delegates. I move you, sir, that the delegates who have been so recorded be seated.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: All those in favor say, "Aye," contrary, "No." The motion is carried. The next order of business is the Roll Call. To save the time of the House, if there is no objection, we will postpone the Roll Call until the recess session. Do I hear any objections? The Roll Call will be postponed until the evening session. The Secretary will announce the place and time of the 1943 session.

Re: Annual Session in 1943 Will be Held in Del Monte

SECRETARY KRESS: Mr. Speaker, the Council recommends to the House of Delegates that Hotel Del Monte be the meeting place for the Convention of 1943. The time will be determined by the Council at a later date. (Applause.)

Election of Officers

SPEAKER GOIN: The next order of business is the election of officers. Nominations are now open for the office of President-elect. Doctor Carr of San Francisco.

President-Elect: Karl M. Schaupp Elected

DOCTOR CARR, San Francisco: Mr. Speaker and Members of the House of Delegates: I would like to nominate for President-elect of the California Medical Association, Doctor Karl Schaupp. (Applause.) This nomination comes, of course, as the unanimous choice of the San Francisco delegation and of the San Francisco City and County Medical Society and, I think, probably comes from the hearts of all of us. It is asking a lot, I know, of a man of Doctor Schaupp's practice and of burdens at present to take this position and at such a time. He has, as you know, one son about to enter the service and one son still in Medical School, together with numerous other professional responsibilities and duties. We all know him, however, as a man who is so eminently suited to the position and in addition so deserving, that it is a great pleasure to present his name. (Applause.)

SPEAKER GOIN: Doctor Karl Schaupp is now nominated. Are there any further nominations? If there are none, the Chair will declare the nominations closed. Hearing none, the nominations are closed. How will we vote?

UNIDENTIFIED VOICE: By acclamation!

SPEAKER GOIN: All those in favor say, "Aye," contrary, "No." Doctor Schaupp is unanimously elected. (Applause.) (Vice-Speaker Askey takes the Chair.)

Speaker of the House: Lowell S. Goin Elected

VICE-SPEAKER ASKEY: The next office to be filled is Speaker for the House of Delegates. Are there any nominations for this office? Doctor Pallette.

DOCTOR PALLETTE: Gentlemen, I have in my library at home several hundred Lincoln books. Lincoln has said very many wise things, but you will all remember very well, it was he who said, "Do not change horses in the middle of the stream." We are in the middle of the stream. I have sat through ten or twelve meetings of the House of Delegates of the American Medical Association and had opportunity to observe several speakers in action there. I have also observed more or less closely several speakers in this House of Delegates, and I am very glad that I am able to say now that I have not known of any speaker in any medical group who is quite as efficient as the Speaker that this House has had during the last couple of years. I take great pleasure in nominating Doctor Lowell Goin to succeed himself. (Applause.)

VICE-SPEAKER ASKEY: You have heard the nomination of Doctor Goin. Are there further nominations for this office?

UNIDENTIFIED VOICE: I move the nominations be closed.

UNIDENTIFIED VOICE: I second the motion.

VICE-SPEAKER ASKEY: It is not necessary to have a motion. Hearing no further nominations the Chair declares the nominations are closed. How will you vote.

UNIDENTIFIED VOICE: By acclamation!

VICE-SPEAKER ASKEY: All those in favor say, "Aye," opposed, "No." Doctor Goin is elected Speaker of the House. (Applause.) (Speaker Goin resumes the Chair.)

Vice-Speaker: E. Vincent Askey Elected

SPEAKER GOIN: Thank you gentlemen. The next office to be filled is that of Vice-Speaker. Doctor Kiger of Los Angeles.

DOCTOR KIGER: I would like to place in nomination the name of E. Vincent Askey. I have placed his name in nomination every time he has come up, so I guess I will have to do it again. (Applause.)

SPEAKER GOIN: Doctor Askey is nominated. Are there any further nominations? If there are none, the Chair will declare the nominations closed. Hearing none, the nominations are closed. How will you vote? All in favor say, "Aye," contrary, "No." Doctor Askey is unanimously elected. (Applause.)

District Councilors: Donald Cass, R. Stanley Kneeshaw, and Frank A. MacDonald Elected

We now come to the nominations for District Councilors.

Councilor for the Second District, Doctor Donald Cass, incumbent, term expiring. Doctor Alesen of Los Angeles.

DOCTOR ALESEN: It gives me great pleasure to endorse the nomination of Doctor Cass to succeed himself, for Councilor of the Second District.

SPEAKER GOIN: Doctor Cass is nominated. Are there any further nominations? If there are none, the Chair will declare the nominations closed. Hearing none, the nominations are closed. Will you vote by acclamation? All in favor say, "Aye," contrary, "No." Doctor Cass is unanimously elected.

Councilor of the Fifth District, Doctor Stanley Kneeshaw of San Jose, incumbent, term expiring. Doctor Shephard of San Jose.

DOCTOR SHEPHARD: The delegates from the Fifth Council District by the Rules and By-laws have placed in nomination their candidate for the Councilor of the Fifth District with the Secretary.

SECRETARY KRESS: Mr. Speaker, the Fifth Council District delegates have presented in writing the nomination of R. Stanley Kneeshaw.

SPEAKER GOIN: Doctor Kneeshaw is nominated. . . . Doctor Kneeshaw is elected. (Applause.)

The Eighth District. Doctor Frank MacDonald of Sacramento, incumbent, term expiring. Doctor Scatena of Sacramento.

DOCTOR SCATENA: The delegates from the Eighth District, through written nomination, wish to place in nomination the name of Doctor MacDonald to succeed himself.

SPEAKER GOIN: Doctor MacDonald is nominated. . . . Doctor MacDonald is elected. (Applause.)

Councilors-at-Large: Sam J. McClendon and Edwin L. Bruck Elected

Councilors-at-Large, Doctor Sam McClendon of San Diego, term expiring. Doctor Johnston of Orange County.

DOCTOR JOHNSTON: The delegates of the First District met together and desire to have the name of Doctor Sam McClendon placed in nomination to succeed himself.

SPEAKER GOIN: Doctor McClendon is nominated. . . . Doctor McClendon is elected. (Applause.)

Doctor Edwin L. Bruck of San Francisco, term expiring. Doctor Garland of San Francisco.

DOCTOR GARLAND: We wish to place in nomination the name of Doctor Edwin L. Bruck to succeed himself.

SPEAKER GOIN: Doctor Bruck is nominated. Are there any further nominations? . . . Doctor Bruck is elected. (Applause.)

Delegates to A.M.A.: Edward N. Ewer, Edward M. Pallette, Robert A. Peers, Wm. R. Molony, and Dwight L. Wilbur Elected

The Delegates to the American Medical Association. Edward N. Ewer of Oakland, term expiring. He is an incumbent. Doctor Jelte.

DOCTOR JELTE: I would like to place in nomination the name of Edward N. Ewer, in behalf of the Delegates from Alameda County.

SPEAKER GOIN: Doctor Ewer has been nominated. . . .

Doctor Ewer is elected. Doctor Edward M. Pallette of Los Angeles, incumbent, term expiring. Doctor Brownfield of Los Angeles.

DOCTOR BROWNFIELD: It gives me pleasure to place in nomination the name of Doctor Edward Pallette to succeed himself.

SPEAKER GOIN: Doctor Pallette is nominated. Are there any further nominations? Hearing none, the nominations are declared closed. All in favor of the election of Doctor Pallette say, "Aye," contrary, "No." Doctor Pallette is elected. (Applause.) Doctor Robert A. Peers of Colfax, term expiring. Doctor Miller of Placer-Nevada-Sierra County.

DOCTOR MILLER: I would like to enter the nomination of Doctor Peers to succeed himself.

SPEAKER GOIN: Doctor Peers is nominated. Are there any further nominations? . . . Doctor Peers is elected. (Applause.)

Doctor William R. Molony, Sr. of Los Angeles, term expiring. Doctor Hayes.

DOCTOR HAYES: I would like to place in nomination Doctor W. R. Molony, Sr., to succeed himself.

SPEAKER GOIN: Doctor Molony is nominated. . . . Doctor Molony is elected. (Applause.)

DOCTOR CHANDLER: I would like to place in nomination the name of Dwight Wilbur to fill the unexpired term of Doctor Best.

SPEAKER GOIN: Doctor Chandler has nominated Dwight Wilbur. Doctor Wilbur is nominated. Are there any further nominations. . . . Doctor Wilbur is elected.

Alternates to A.M.A.: Frank R. Makinson, William H. Kiger, Frederick Scatena and Ralph Eusden Elected

Alternates to the American Medical Association. Each alternate elected is an alternate to a particular delegate.

The first alternate is an alternate to Doctor Ewer. Doctor Makinson is the present incumbent, term expiring. Doctor Smith of Alameda County.

DOCTOR SMITH: The delegation of the Alameda County wishes to place in nomination the name of Frank R. Makinson to succeed himself.

SPEAKER GOIN: Doctor Makinson is nominated. Are there further nominations? . . . Doctor Makinson is elected.

Alternate to Doctor Edward N. Pallette. William H. Kiger of Los Angeles, incumbent, term expiring. Doctor Blatherwick.

DOCTOR BLATHERWICK: The Los Angeles delegation takes pleasure in placing in nomination the name of Doctor Kiger to succeed himself.

SPEAKER GOIN: The name of Doctor Kiger has been placed in nomination. . . . Doctor Kiger has been elected.

Alternate to Doctor Robert A. Peers. Frederick Scatena of Sacramento, incumbent, term expiring. Doctor

Jones of Sacramento.

DOCTOR JONES: Mr. Speaker, I should like to place in nomination the name of F. N. Scatena to succeed himself as alternate to Doctor Peers.

SPEAKER GOIN: Doctor Scatena has been nominated. . . . Doctor Scatena is elected.

* * *

Alternate to William R. Molony, Sr. Doctor John C. Ruddock, incumbent, term expiring. Doctor Wilcox.

DOCTOR WILCOX: I would like to place in nomination the name of Doctor Eusden of Los Angeles. Dr. Ruddock is in service and states he cannot act as alternate.

SPEAKER GOIN: Doctor Eusden has been nominated. . . . Doctor Eusden is elected.

* * *

Standing and Special Committees

The Special Committee on Nominations of Committee Members will kindly announce the members of the Standing Committees elected by the Council, with the approval of the House.

SPEAKER GOIN: The Chair recognizes Doctor Kneeshaw.

DOCTOR KNEESHAW: Your committee respectfully reports the selection of the following personnel for your Standing and Special Committees for 1943.*

Committee on Associated Societies and Technical Groups:
Clarence Rees, M. D., San Diego.....1945
John V. Barrows, M. D., Chairman, Los Angeles..1943
Edwin L. Bruck, M. D., San Francisco.....1944

Committee on Health and Public Instruction:
J. C. Geiger, M. D., San Francisco.....1943
John Ruddock, M. D., Chairman, Los Angeles....1944
Cecil M. Burchfiel, M. D., San Jose.....1945

Committee on History and Obituaries:
Hyman Miller, M. D., Los Angeles.....1943
Morton Gibbons, M. D., Chairman, San Francisco.1944
Robert A. Peers, M. D., Colfax.....1945
George H. Kress, Secretary-Editor, Ex Officio

Committee on Hospitals, Dispensaries and Clinics:
Benjamin Black, M. D., Oakland.....1943
Walter Rappeport, M. D., U.S. Navy, Mare Island.1944
J. Norman O'Neill, M. D., Chairman, Los Angeles.1945

Committee on Industrial Practice:
George H. Sanderson, M. D., Stockton.....1943
Wilbur Cox, M. D., San Francisco.....1944
Donald Cass, M. D., Chairman, Los Angeles.....1945

Committee on Medical Defense:
Lewis T. Bullock, M. D., Los Angeles.....1943
Nelson Howard, M. D., Chairman, San Francisco.1944
Stanley Kneeshaw, M. D., San Jose.....1945

Committee on Medical Economics:
Glenn Cushman, M. D., Chairman, San Francisco.1943
Edward C. Pallette, M. D., Los Angeles.....1944
Charles A. Broaddus, M. D., Stockton.....1945

Committee on Medical Education and Medical Institutions:
Fred H. Kruse, M. D., San Francisco.....1943
B. O. Raulston, M. D., Chairman, Los Angeles...1944
L. R. Chandler, M. D., San Francisco.....1945

Committee on Membership and Organization:
L. H. Redelings, M. D., San Diego.....1943
Louis Alesen, M. D., Chairman, Los Angeles.....1944
J. F. Doughty, M. D., Tracy.....1945

Committee on Postgraduate Activities:
Francis Rochex, M. D., Chairman, San Francisco.1943
Fred Clark, M. D., Vice-Chairman, Long Beach..1944
(To fill the unexpired term of F. E. Clough, M. D., resigned.)
Frank MacDonald, M. D., Sacramento.....1945
George H. Kress, Secretary, Ex Officio
We recommend that Dwight Wilbur, M. D., San Francisco, act on the Advisory Committee.

Committee on Publications:
George W. Walker, M. D., Chairman, Fresno.....1943
F. Burton Jones, M. D., Vallejo.....1944
(To fill the unexpired term of Doctor Alexander of Oakland, deceased.)
Francis E. Toomey, M. D., San Diego.....1945
George H. Kress, Secretary-Editor, Ex Officio

Committee on Public Policy and Legislation:
E. T. Remmen, M. D., Los Angeles.....1943
Dwight H. Murray, M. D., Chairman, Napa.....1944
Anthony Diepenbrock, M. D., San Francisco.....1945

Committee on Public Policy and Legislation: Advisory Committee:
Junius B. Harris, M. D., Chairman, Sacramento
H. R. Madeley, M. D., Vice-Chairman, Vallejo

Committee on Scientific Work:
Fletcher B. Taylor, M. D., Oakland.....1943
J. Homer Woolsey, M. D., Woodland.....1944
Howard F. West, M. D., Los Angeles.....1945
Secretary, Section on Medicine [Mast Wolfson, M. D., Monterey], Ex Officio
Secretary, Section on Surgery [J. Norton Nichols, M. D., Los Angeles], Ex Officio
Association Secretary [George H. Kress, M. D., San Francisco], Ex Officio, Chairman

*Cancer Commission:**
[Harold Brunn, M. D., Chairman, San Francisco]
Lyell E. Kinney, M.D., Vice-Chairman, San Diego.1943
Otto H. Pflueger, M. D., Secretary, San Francisco 1943
Orville N. Meland, M. D., Los Angeles.....1944
A. Herman Zeiler, M. D., Los Angeles.....1944
Gertrude Moore, M. D., Oakland.....1944
Alson R. Kilgore, M. D., San Francisco.....1943
Henry J. Ullmann, M. D., Santa Barbara.....1945
Clarence J. Berne, M. D., Los Angeles.....1945

Committee on Public Health Education:
Frank R. Makinson, M. D., Chairman, Oakland
P. K. Gilman, M. D., Chairman, San Francisco
Samuel Ayres (Jr.), M.D., Los Angeles
J. Frank Doughty, M. D., Tracy
Thomas A. Card, M. D., Riverside
Lowell S. Goin, M. D., Los Angeles
Dwight Murray, M. D., Napa
W. R. Molony, M. D., Los Angeles

Committee on Medical Benevolence:
Robert A. Peers, M. D., Colfax
Elizabeth M. Hohl, M. D., Los Angeles
Axcel E. Anderson, M. D., Chairman, Fresno

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Editorial Board

Dwight L. Wilbur, Chairman of the Board

Executive Committee:
Dwight L. Wilbur, M. D., San Francisco
George W. Walker, M. D., Fresno
Albert School, M. D., Los Angeles
Fred D. Heegler, M. D., Napa

Anesthesiology:
Charles F. McCuskey, M. D., Chairman, Glendale
H. R. Hathway, M. D., San Francisco

Dermatology and Syphilology:
H. J. Templeton, M. D., Oakland
W. H. Peckerman, M. D., Los Angeles

* List is as amended.

* Nominations for Cancer Commission received from President-Elect Molony.

Ear, Eye, Nose, and Throat:
Fredrick C. Cordes, M. D., San Francisco
L. G. Hunnicutt, M. D., Pasadena
George W. Walker, M. D., Fresno

General Medicine:
Garnett Cheney, M. D., San Francisco
Mast Wolfson, M. D., Monterey
George Houck, M. D., Los Angeles

General Surgery, Including Orthopedics:
Fred C. Bost, M. D., San Francisco
Clarence J. Berne, M. D., Los Angeles
Fred D. Heegler, M. D., Napa

Industrial Medicine and Surgery:
John E. Kirkpatrick, M. D., Shasta Dam
John D. Gillis, M. D., Los Angeles

Plastic Surgery:
George W. Pierce, M. D., San Francisco
William S. Kiskadden, M. D., Los Angeles

Neuro-Psychiatric:
John B. Doyle, M. D., Los Angeles
Olga Bridgman, M. D., San Francisco

Obstetrics and Gynecology:
Earl Hendriksen, M. D., Los Angeles
Daniel G. Morton, M. D., San Francisco

Pediatrics:
William A. Reilly, M. D., San Francisco
William W. Belford, M. D., San Diego

Pathology and Bacteriology:
David A. Wood, M. D., San Francisco
R. J. Pickard, M. D., San Diego

Radiology:
R. R. Newell, M. D., San Francisco
Henry J. Ullman, M. D., Santa Barbara

Urology:
Lewis Michelson, M. D., San Francisco
Albert Soiland, M. D., Los Angeles

Pharmacology:
Chauncey P. Leake, M. D., San Francisco
Clinton H. Thienes, M. D., Los Angeles

* * *

Further Recommendations:

Section A.—We respectfully recommend that legal counsel of the California Medical Association be instructed to draw up the necessary amendments to the by-laws for the deletion of the following Standing Committees.

1. Committee on Membership and Organization, by reason of their own suggestion as printed in the Pre-Convention Bulletin which indicates the Committee unnecessary.

2. The Committee on Publications, because last year the Editorial Board was created, and the Committee's duties were largely taken over by the new Board.

Section B.—We suggest that the Executive Members of the Standing Committees be circularized by the Association's Secretary for names of new Advisory Members to be appointed in accord with the Section 4, Chapter V, of the By-Laws. This to be done to add to the effectiveness of the work of the Committees and, further, that this Special Committee on Personnel of Committees of the Council be continued until such appointments have been made.

Section C.—It is further suggested that Commission Members who are now in the Commissioned Armed Services be contacted by the Association's Secretary to determine whether or not they wish to continue to serve on their respective Committees.

Respectfully submitted,
JOHN W. GREEN, *Chairman.*
EDWARD B. DEWEY
STANLEY KNEESHAW

DOCTOR KNEESHAW: I wish to move the adoption of this report.

SPEAKER GOIN: Doctor Kneeshaw moves the adoption of the report. Is there a second?

DOCTOR BRUCK: I second the motion. . . . The report is adopted.

* * *

In Memoriam

During the past year, Members of the House, we have lost 74 of our members, friends, colleagues, by death. Perhaps the House would like to stand for a moment in tribute to this group. (List of deceased members appeared in April issue of CALIFORNIA AND WESTERN MEDICINE, on page 216.)

(House stood for one minute.)

* * *

Recess

The Chair will entertain a motion to recess at this time, to convene again at 8 o'clock. It has been moved by Doctor Doughty of San Joaquin and seconded by Doctor Bailey. All in favor say, "Aye," contrary, "No." The House will be in recess until 8 o'clock.

* * *

Second meeting of the House of Delegates, at the 71st Annual Session recessed at 5:40 p.m., on Wednesday, May 6, 1942.

* * *

After-Recess Meeting

House of Delegates: Reconvened at 8:30 p.m.

VICE-SPEAKER ASKEY: Will the House be in order. . . . Does the Credential Committee have a further report to make at this time? If there is nothing further from the Credentials Committee, we will proceed with the Roll Call, to constitute the House officially. Mr. Secretary, at the time of the Roll Call of the Delegates from each individual County, if the Chairman of that delegation wishes to seat an alternate, he will rise, give his name, and state to the Chair the alternate who will sit for the delegate. Mr. Secretary, please call the Roll.

(Secretary Kress called the roll of the House.)

VICE-SPEAKER ASKEY: Councilor Anderson is sick in bed, and that is the reason he is not here. The roll call having been completed, we will proceed. Is there a quorum present, Mr. Secretary?

SECRETARY KRESS: Mr. Speaker, a quorum is present.

VICE-SPEAKER ASKEY: A quorum being present, this House is declared duly open and constituted for further business. At this time, we will have a report from the Chairman of the Committee on Scientific Work, Doctor Kress, in regard to scientific prizes. Doctor Kress.

* * *

Report of Committee on Awards for Scientific Exhibits

SECRETARY KRESS: Mr. Speaker, the Secret Committee on Scientific Exhibits has reviewed the exhibits and reports as follows:

1. First Prize (Fifty Dollars and Engrossed Certificate of Award), for best Surgical Exhibit was awarded to James R. Dillon, M. D., San Francisco, for exhibit on *"Conservative Treatment of Cancer of the Prostate."*

2. Honorable Mention (Engrossed Certificate) was awarded to Bernard Strauss, M. D., San Francisco, and Henry Kreutzman, M. D., for exhibit, *"Anatomy of the Perivesical Spaces."*

3. First Prize (Fifty Dollars and Engrossed Certificate of Award) for best Medical Exhibit was awarded to Samuel Ayres, Jr., M. D., Los Angeles, and Nelson Paul Anderson, M. D., Los Angeles, for exhibit, *"Dermatoses Common Under War Conditions."*

4. Honorable Mention (Engrossed Certificate) was awarded to G. R. Biskind, M. D., San Francisco, and Bernard Strauss, M. D., San Francisco, for exhibit, *"Hormonal Treatment of Eunuchoidism."*

The report on the Drawing of Prizes for visits to the Technical Exhibits. Executive Secretary Hunton states that the drawings are not yet completed, and those who won the radio, and the electric clock and fountain pen, will receive their prizes in due course.

REPORTS OF REFERENCE COMMITTEES

At this time, we will come to the report of our various Reference Committees. The first Reference Committee Report is Reference Committee No. 1. Its report on the Reports of the Officers and Standing Committees. The Chairman of that Committee is Doctor J. Norman O'Neill of Los Angeles County. Doctor O'Neill.

* * *

REPORT OF REFERENCE COMMITTEE NO. 1

DOCTOR O'NEILL: Mr. Speaker, your Reference Committee No. 1 to which was referred Reports of the Officers and Standing Committees* begs leave to report as follows:

Report of the President:

The outbreak of the World War No. 2 in the middle of the Association's year brought about profound changes in the program and has produced numerous problems which it will be the duty of the Association's Officers and Councilors to solve. . . .

Today, we face a serious situation. There are a large percentage of medical men who are entering the service of the Army and Navy. This leaves a problem for the physicians who are left at home. From this situation we can expect that the practice of private medicine in civilian communities will undergo a change in the next year or two. If the physicians of the State can meet this changing situation through their own organization, they will be able to control the situation. If they cannot meet this challenge, it is certain that the Government will do so.

We are fortunate in California in having a well organized Medical Service, completely in touch with present and future demands on the medical profession. It is our President's sincere belief that this organization will enable the physicians of our State to remain in control of their own destiny, no matter what changes might come about in medical practice because of the war or Government demands. California Physicians' Service has entered into partnership with the United States Government on two occasions in the year now ending. For the Farm Security Administration, it has contracted to provide adequate medical care for farm families and for the Federal Works Agency. It has agreed to look after the residents of Defense Housing Units in two California locations. Both of these agreements have far reaching significance. The contracts prove at once that C.P.S. is reaching its maturity along the lines of its original conception, and that it is undoubtedly the best bulwark possessed by the medical profession against threatened inroads of Governmental Agencies. Internally, the administrative changes already made and under contemplation by C.P.S. should result in further progress of the organization, and a better return to the participating professional members. Our President, within the last month, has been called upon to do one more duty—the Office of Chairman of the Ninth Corps Area Committee of the Procurement and Assignment Service. This appointment was made immediately after the death of beloved Charles A. Dukes. It carries with it a responsibility for the maintenance of professional standards and medical care for the civilian population, as well as the building of a pool of qualified physicians for military purposes. The functions of this office will be carried out with the thought always in mind of protecting the health of military and civilian population and the conserving to the fullest extent the medical resources available to the country. The Committee recommends the approval of this report.

DOCTOR MADSEN: I second the motion.

VICE-SPEAKER ASKEY: You have heard the motion and the discussion of the motion. If not, all in favor of approving this report say, "Aye," opposed, "No." It is accepted.

Report of the President-Elect:

The President-Elect of the California Medical Association serves, as it were, an apprenticeship in preparation for the real job the following year. . . . The Committee recommends approval of this report.

VICE-SPEAKER ASKEY: I understand that you move the acceptance of Report, Doctor O'Neill. Is there a second to Doctor O'Neill's motion.

DOCTOR DOYLE, Los Angeles: I second the motion.

VICE-SPEAKER ASKEY: Seconded by Doctor Doyle of Los Angeles. Is it accepted? All in favor say, "Aye," opposed, "No." The report is adopted.

Report of the Speaker of the House of Delegates:

The California Medical Association and its House of Delegates will convene this year under the extraordinary circumstances attending war. . . . The Committee recommends the approval of this report.

VICE-SPEAKER ASKEY: . . . The report is adopted.

Report of the Vice-Speaker:

This year has been one of activity for all the Officers of the Association. Our Vice-Speaker has attended by invitation many of the meetings of the Council and has followed the proceedings closely. He has found our Officers to be alert, earnest, and conscientious in all of their actions. The Committee recommends the approval of this portion of the report. . . . The report is adopted.

Report on the Chairman of the Council:

The Council submitted in the Pre-Convention Bulletin a tentative report. At Del Monte an additional report is made. . . .

VICE-SPEAKER ASKEY: . . . This section of the report is adopted.

Report of the President of the Trustees of the California Medical Association:

The Financial Report of the Trustees of the California Medical Association is printed in the Pre-Convention Bulletin as a self-explanatory statement. The non-Profit Corporation Trustees of the California Medical Association has, as its members for the year, the general Officers and the Councilors of the Association of that year. The Corporation, in accordance with the corporate laws of the State, meet as the custodian of endowment and special funds that may be transferred to it for custodial supervision and care. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: . . . This section of the report is adopted.

Report of the Legal Department:

. . . This Report, among other things, sets forth the

* The reports here discussed appeared in the April issue of CALIFORNIA AND WESTERN MEDICINE "Pre-Convention Bulletin" supplement, on pages 200 to 226. In the minutes as here printed, whether or not stated, the Pre-Convention Reports were accepted and adopted, unless otherwise noted.

legal aspects of the more important legislative bills affecting medicine which became law at the last session and legislative work in preparation for the next. . . . The Supplementary Report by our General Council, dealing with the infiltration of State Medicine through many Executive and Administrative Agencies of the Federal Government, should receive our thoughtful consideration. The Committee recommends the approval of this section of the report.

VICE-SPEAKER ASKEY: . . . This section of the report is adopted.

Report of the Editor:

At the last annual session, the House of Delegates authorized the appointment by the Council of an Editorial Board of thirty members, consisting of representatives of fourteen specialty groups with an Executive Committee. During the past year, under the new arrangement, manuscripts have been referred to various Board members for opinions and suggestions. . . . During the last year, consequently, in order to hold down the printing cost, the issues have been limited to 96 pages, of which 56 pages were available for text material, divided between articles dealing with scientific and organized medicine. Also, in order to produce a publication at less cost than formerly, a change of printer was authorized by Council. The first issue, under the new arrangement with the printing done in Los Angeles and the Editorial Offices in San Francisco, appeared in January, 1942. Before judgment is passed on the set-up, it will be necessary to bring off from the press at least five or six issues. In the meantime, every effort is being made to produce a publication that will measure up to the typographical standards of former years. The new procedure threw much extra work on the Editorial Office, since the interchange by mail, instead of by direct messenger contact, naturally makes for a certain amount of delay. During this transition period, therefore, the contributors are requested to make due allowance. Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: . . . This portion of the report is adopted.

Report of the Executive Committee:

The Executive Committee has had very little call on its services in the past year. . . .

VICE-SPEAKER ASKEY: . . . This portion is adopted.

Report of the Auditing Committee:

The Auditing Committee has performed the functions laid down in the by-laws. The professional audit of the Association books by the Certified Public Accountants showed them to have been accurately kept and the Committee has submitted its recommendation for the 1943 Budget. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: . . . The section is adopted.

Report on Associated Societies and Technical Groups:

In their separate localities, whenever possible, they have the aid of the Woman's Auxiliary, the Nurses' Association, and the Technician and Hospital Groups. . . .

Report of the Committee on Health and Public Instruction:

The individual members of the Committee have all been actively engaged in Civilian Defense Programs in their various localities. . . .

Report on Histories and Obituaries:

The Committee on Histories has made plans to proceed with collection of historical data, and is happy to announce that it has secured from relatives in Georgia a copy of the painting of a founder of the Medical Society of the State of California—now the California Medical Association—the late Benjamin Franklin Keene. The painting will be given a place of honor in the Association offices, and is now on display in the lower corridor of the Hotel Del Monte. The County Medical Societies are again urged to appoint Committees with responsibility to gather for a record book for future use the compilation of history of their respective units. A list of members who died during the year 1941 numbers 70 more. . . .

Report on Hospitals, Clinics, and Dispensaries:

This report indicates that during the year 1942 a great percentage of the private practice of medicine in the County of Los Angeles may be supplemented by socialized medicine, and the Committee suggests three plans of action:

(1) A new appropriation bill is being enacted by Congress at the present time, providing another 150 million dollars for assisting non-profit public and private hospitals, and other public facilities. We should organize a plan to secure some of these funds for the private hospitals in the State of California.

(2) We should set up a plan for tabulating and clearing all private patients who need hospitalization and are unable to secure it in private hospitals. Some methods should be devised for taking care of these patients so that they are not forced to go to the County Hospital.

(3) A plan should be devised and recommended to each physician so that all borderline private patients who cannot pay both private hospital and physician are referred to the County Hospital; thus, leaving the beds in the private hospitals for the patients who can pay both physician and hospital. In other words, if we must force patients to go to the County Hospital, let us force the indigent patient to accept these facilities. The Committee recommends that the State Medical Society consider the problem of hospitalization as one of their main objectives during the first part of 1942. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: The Committee moves the adoption of this portion of the report. Is there a second?

DOCTOR DEWEY: I second the motion.

VICE-SPEAKER ASKEY: Seconded by Doctor Dewey of Pasadena. All in favor say, "Aye," opposed, "No." Doctor Halley wishes to discuss this section of the report. The question has not been taken yet.

Discussion:

DOCTOR HALLEY, San Joaquin: Relative to the first recommendation, "a new appropriation bill is being enacted by Congress at the present time providing another 150 million dollars for assisting non-profit private and public hospitals and other public facilities. We should organize a plan to secure some of these funds for private hospitals in the State of California." I think that carries implications which perhaps this House of Delegates would not like to officially approve. I attempted to take this up with the Committee, but since there was a criss-cross between two activities by the same Chairman, he felt that it should be brought forward here. This item may be presented. The Federal services (United States Civil Service Employees' Compensation Commission), of whom there are a great many members appearing around the State in these Army Post activities and so forth, are being forced into private hospitals at $3.75 a day.

I doubt if any hospital, certainly very few, operate their ordinary service facilities without taking into consideration the overhead, repair, deterioration, etc. Now, if these hospitals, under our encouragement, are put into the position of accepting grants or loans, their bargain-

ing power in connection with that item is reduced. Having lost the effectiveness of their bargaining power, it is only a matter of time until the mounting deficits from operating at below cost will put them directly back into Uncle Sam's hands. And perhaps we will lose the thing we are trying to save. The other implication is that, if we approve a plan to go after these funds on behalf of the hospitals, many of our friendly enemies in the Federal Services will take this official action and misinterpret it to their own benefit.

Therefore, Mr. Speaker, I move the deletion of the first subdivision concerning the new appropriation bill, etc., and through "we should organize a plan to secure some of these funds for the private hospitals in the State of California."

VICE-SPEAKER ASKEY: Your motion is an amendment to the motion to adopt the portion of the report. Is there a second to the motion?

DOCTOR DOUGHTY: I second the motion.

VICE-SPEAKER ASKEY: The motion is to strike the words referred to from this section of the report. Doctor Green.

DOCTOR GREEN: I wish to take the opposite side in this discussion. In my own experience, in a concrete instance in Vallejo, the Government offered a subsidy to our hospital, which has only 78 beds, of $150,000. The private owner and manager of this hospital, being a gentleman of some 82 years, decided that he did not want to have anything to do with it. So consequently to date we still have 78 beds. Now, that forced us into the position, not being able to have a private hospital, of having a public hospital. So, with those few words, I want to commend Doctor O'Neill's recommendation.

VICE-SPEAKER ASKEY: Is there further discussion on this amendment to the motion? Doctor Doughty.

DOCTOR DOUGHTY: Mr. Speaker, I think Doctor Green misinterprets Doctor Halley's motion. His intentions deal with cutting out the reference to appropriations. Dr. Halley does not wish our antagonists to quote from our minutes and be able to state that we have approved their plans and so permit them to use such a statement as propaganda for Federal Socialized Medicine. He is not opposed to the policy, but he is opposed to putting it down in black and white, because he thinks it might be misused for propaganda.

VICE-SPEAKER ASKEY: Is the purpose of the amendment understood? Is there further question or discussion?

DOCTOR GREEN: The question is, sir, how to get hospital beds?

DOCTOR HALLEY: The point is more whether the Committee of the California Medical Association should officially support the program, not how to get hospital beds.

VICE-SPEAKER ASKEY: There seems to be a disagreement, not as to what is to be done, but as to how to do it, and that is the purpose of the amendment as I see it. Is there further discussion? Doctor Ward.

DOCTOR WARD: I wonder if approval of the California Medical Association would affect the decision of the 78-year-old manager of this hospital.

DOCTOR SHEPHARD: I think this question comes right down the alley of the Committee which was appointed last year, of which I was Chairman, in regard to hospitalization subsidy. To the few of you who have been following the trend of the Government in an attempt to force State medicine down our throats, and particularly those of you who have followed the report of the Social Security Board, cannot help but realize that we not only have State medicine as a threat against us, but that it is already here to a large extent. Last year, over 50 per cent of the patient days in the State of California were spent in tax-supported hospitals. After this War is over, it takes no crystal gazer to realize that there will be a great many more citizens hospitalized at Government expense. To me it seems that this is the first opportunity that is offered us to segregate, or to trade with the Government, and preserve for us the private practice of medicine; whereas the hospitalization problem is going to be taken care of out of taxation. You will remember, also, that the Social Security Board in a recent recommendation, which is not incorporated in its annual report, does recommend that they all come under Social Security Benefit, of which there are some thirty million at the present time and will receive a subsidy for hospitalization, tentatively recommended by the Social Security Board, of about $3 per day. If we can get our hospitalization taken care of through some form of compulsory hospital insurance, which means tax-supported institutions, then you and I and the rest of the doctors in the country will administer medical care, and in that way we will save for ourselves the private practice of medicine; whereas hospitalization can become, and probably will become, a State and Federal job. I believe that if the Federal Government is willing to enter in to the establishment of hospital beds, and we will get behind the program and will direct the matter in which this is to be put into operation, we can save for ourselves the private practice of medicine. Now let's go back into history just a little bit. There are some of you men here from Los Angeles who were active in the practice of medicine at the time the California Employers' Act was passed, the State Compensation Bill. If I am correctly informed, the Los Angeles County Society at that time were so strongly opposed to any form of Compensation Insurance that, by resolution or by modification of their by-laws, any member of the Los Angeles County Medical Society that indulged in compensation practice would be deprived of his membership in the Los Angeles County Medical Society. If I am in error in my statement, please correct me. At least that is what I have been very definitely informed. In other words, at the time that the Compensation Bill was passed, there was no coöperation nor directing influence through the medical profession; consequently, we had choked down our throats the thing which none of us have been particularly fond of. I believe that, if we are going to direct the course, we have got to lend a helping hand and by so doing, perhaps, and only perhaps, we may be able to save the one thing in the practice of medicine which you and I want and that is the medical service.

VICE-SPEAKER ASKEY: Is there any further discussion? Doctor Pallette.

DOCTOR PALLETTE: Gentlemen, I would like to put Doctor Shephard right on his statement in regard to the Los Angeles County action in regard to the State Compensation Act. In the first place, the action was not taken at all, because it was voted down, and the action was merely attempted because the men who made the motion and were supporting it objected to the Fee Schedule as being too low and not objecting to the principle itself. Now, if I may speak on the motion to delete. . . . I support the motion to delete.

VICE-SPEAKER ASKEY: Further discussion? Doctor Madeley of Solano.

DOCTOR MADELEY: I think what I am going to say is probably something that everyone knows, but I don't think Government subsidy of hospitals is going to help the medical profession. The Government doesn't invest money and not look after the money it invests. If the Government is going to build hospitals and provide hospital beds, it is going to run them after they have built them. I think that if we allow them to build hospitals, and provide beds for our civilians, it will put

them under complete Government subsidy, and not aid the private practice of medicine. I support the deletion motion of Doctor Halley.

VICE-SPEAKER ASKEY: Doctor Carr of San Francisco.

DOCTOR CARR: After the last address, gentlemen, this is redundant, I know, but it appeals to us that this is an insidious move; that it is an infiltration project whereby the Government does seek to control the practice of medicine. If you look over the Government hospitals of which we are conscious at present, you will find that they do not control the hospitalization, excepting by controlling the practice of medicine. It is my feeling that this so-called helping hand which we are about to extend is going to return to us as a hot hand in the seat of our pants, and I think we had better avoid it. (Applause.)

VICE-SPEAKER ASKEY: Doctor Hope, do you wish to discuss it?

DOCTOR HOPE: I think one little point might be brought out, that in C.P.S.'s negotiations back in Washington in the setting up of the Linda Vista project, during the course of the talks, one of the arguments brought out by individuals who are very strongly interested in setting up Government Bureaus for caring for these projects and extending into other projects for the fact that medical care could be given at a cheaper rate if the overhead was brought down. I think that the compulsory hospital insurance with Government-run hospitals would be the first step to amalgamating the clinics that were set up in cutting down that overhead and I think it is an insidious step. There is a very definite trend of thought along that line. I don't believe that a complete subsidy would help it.

DOCTOR ROGERS: I simply want to call to your attention how the funds have already been expended in California. I think at the present time this 150 million dollars, previously referred to, has been increased to 375 million. The Committee from Washington, which visited California, inspected a lot of hospitals, and put several hundred beds in Los Angeles General Hospital with the provision that they must accept their patients. I think they put 100 beds in the Solano Hospital, didn't they, with the provision that we must accept their patients. This money in a big majority of cases is going into the already tax-supported hospitals, with the stipulation that the hospitals must accept their patients. . . .

VICS-SPEAKER ASKEY: Doctor Green.

DOCTOR GREEN: I wish to say this, that under ordinary circumstances before war was declared I would agree with that entirely, absolutely. I thought that thing before, but now we have a war and now we have places where we must have hospitals. They offered our hospital 150 thousand dollars to increase its facilities a year ago for our purposes. The managers, I say, and owners refused, so consequently even now in this emergency we have no beds. We have to find beds for our patients in a hospital somewhere around the Bay District, but had we been smart or had we been able to prevail upon that owner and manager to accept the proposal, we would now have some private beds, even though through Government subsidy. But now, we have been struggling to find beds for patients for six months. We still have no beds, but when we do get a hospital, it will be a city hospital, owned by the Government, run by the Government, through the city as administrator, and we won't have a thing to do with it except to staff it.

VICE-SPEAKER ASKEY: Doctor Sharpe of Monterey County.

DOCTOR SHARPE: Mr. Speaker, Mr. Chairman, Members of the House of Delegates: I had a little experience with this situation. About a year ago, we were faced in Monterey County with the problem of the hospitalization of the dependents of many of the enlisted personnel in the Army. We were asked in the County Hospital if we could and would take care of these people. We did not have the facilities; therefore, when the Flanham Act was passed, we made application for a grant, primarily for maternity beds and for isolation. To date we haven't seen any of the money. Now, the application for our grant was sent forward in June. Since then, we have had a changing picture in our community, in that we have not had the need for these beds, because the change in the military establishment, has not brought the dependents upon us. However, the Government came to us and still wished to proceed with giving us the grant on the stipulation that we accept pay patients. And in our community, we felt that we would not be the Government's guinea pigs of the State of California, because the State law did not permit us to accept pay patients. That being the situation, we could not proceed on that basis.

Now if anyone reads the original act which provided the first 150 million dollars, there is a section that says that the Government shall have nothing to do with the personnel, the administrative policies, the management, or anything else in the institution. Nevertheless, we have been informed that, despite the provisions of the act, we should and could accept some such patients. We were given a grant, but nothing has happened and nothing has been built. We need more hospital beds in our community. In a certain portion of Monterey County there is an acute need for private hospital beds, and on that basis a hospital project was sponsored and a certain amount of money was raised, insufficient however, to provide the required number of beds. I believe that an application is before the Federal Government at this time for funds to complete that project. If such goes through under the terms of the present act, I do not see how there can be any regulation of the institution, the management, or its policies. In any supplementary bill, the act may be changed and there might be an opportunity for such intereference in the management of the institution, but in the act passed so far, if the letter of the law is adhered to, there can be no interference.

VICE-SPEAKER ASKEY: Is there further discussion on this amendment to the motion? The question will be upon the amendment to the motion which is to delete a part of the report given by Doctor O'Neill. All in favor of the amendment say, "Aye," opposed, "No." We will have a standing vote, please. All in favor of the amendment please stand. Opposed please rise. The amendment is carried.

The question now comes from the motion as amended. This is sort of a paradoxical thing because the motion was to accept it where the amendment was to delete it, so in order to carry your amendment, you must pass the motion. Is that understood? In other words, the motion has been amended. If you wish the amendment to be carried, the motion must be carried even though it states the opposite from the amendment. Is that correct, Mr. Speaker?

SPEAKER GOIN: Just part of the motion was amended.

VICE-SPEAKER ASKEY: I mean, the motion as deleted. All in favor of the motion as amended say, "Aye," opposed, "No." The motion is amended. Mr. Chairman would you proceed with the report.

* * *

Report of the Committee on Industrial Practice:

The questionnaires submitted by the American Medical Association have been completed as much as possible and your Committee has furnished the Federal Government through the American Medical Association Headquarters with lists of all of those in the State who have practiced industrial surgery and have given their qualifications as rendered in the forms submitted.

The Committee believes that it would be advisable to have a qualified industrial hygienist on this Committee. The Committee recommends the approval of this portion of the report.

Report of the Committee on Medical Economics:

The past year has not produced any marked trend in medical economics. The California Physicians' Service has quietly put into force contracts which most certainly will prove to be very far-reaching in the effect on the threat of State medicine if the profession will continue to give it full support. The Committee recommends the adoption of this portion of the report. . . .

VICE-SPEAKER ASKEY: It is adopted.

Report of Committee on Medical Education and Medical Institutions:

It is interesting to report that each of the four medical schools in California has adopted as a war emergency measure a program of medical education by eliminating the long summer vacations and scheduling their courses, ordinarily given during four calendar years in a continuous manner, so that classes entering in the summer of 1942 will graduate in three calendar years. The Committee recommends the approval of this portion of this report.

This section of the report is adopted.

Report of Committee on Membership and Organization:

The Committee on Membership and Organization has held no meetings and conducted no activities, largely because of the efficient management of the Association's Central Office. . . .

VICE-SPEAKER ASKEY: This section is adopted.

Report of the Committee on Postgraduate Activities:

It is the hope of the Committee that, with the coöperation of members of the Armed Forces, staff members of the Medical Schools in the State, and other physicians informed in regard to these matters, programs having to do in particular with treatment of fractures, treatment of burns, treatment of gas casualties, and treatment of acute emergency such as shock, and hemorrhage may be brought before many of the County Societies throughout the State. This program is being developed at the present time. Fourteen postgraduate conferences were held during the year 1941. The Committee recommends the approval of this portion of the report.

This section is adopted.

Report of Committee on Public Policy and Legislation:

The closing week of the Legislature found the Legislative Committee very busy. During the entire 1941 session, there were 4,381 bills introduced; of this number 376 had some reference to Public Health. Perhaps the Bill which caused the Committee the greatest activity was the AB1475 reference to alien doctors. This Bill was vetoed by the Governor. For the first time this Committee attempted to pass a bill over the Governor's veto. It succeeded in doing this because of the intelligent and persistent generalship of Assemblyman Roger B. Pfaff. (Applause.)

In January, 1942, the Governor called a special meeting of the Legislature for the purpose of considering the State Guard Bill. Since the Adjutant General had previously appointed a man to fill a very important position in the Medical Department of the California State Guard, it was deemed advisable to have the qualifications of the medical officers made clear. The Committee was able to do this by stating in the Bill, which was passed by the Legislature, that medical officers of the State Guard should have the same qualifications as those of the Army and Navy. It was further specified in the Bill that any medical officer in the service whose qualifications did not meet with these regulations should be dropped at once. The Committee considers this an important piece of legislation and was very happy to secure its passage.

An informal conference was also held with representatives of the labor groups. This conference was requested in an effort to learn what were the wishes of organized labor regarding the care of citizens coming under the provisions of the California Industrial Accident Law. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: This section of the report is adopted.

Report of the Committee on Public Relations:

This Committee has had no meetings during the past year. This Committee feels that the field of Public Relations should include the education of our own members of the California Medical Association to a better understanding of the work being accomplished by the Head Office, by the Council, and by the House of Delegates. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: Is there a discussion on this? If not, all in favor say, "Aye," opposed, "No." This section of the report is adopted.

Report of the Cancer Commission:

The Commission wishes to report that all meetings which it sponsored during the past year have been most successful. The clinical session at the last State meeting was attended by about 300 persons and was a most excellent meeting. The members of the Cancer Commission have continued to act as the Executive Committee for the Women's Field Army of the American Society for the Control of Cancer. The Committee recommends the approval of this section of the report.

VICE-SPEAKER ASKEY: It is carried.

Report of the Committee on Public Health Education:

The principle project for the year was an assignment to this Committee by the Council for promotion of the campaign for securing signatures to place the basic science on the ballot. This proposed initiative was given to the Committee by the Council after it had been drafted by the Public Relations Committee, and after it had been approved by allied groups through the efforts of that Committee. The Committee on Public Health Education, at its February meeting, outlined the instructions which accompanied the petitions, and financed and oversaw the preliminary distribution of the initiative petitions to physicians, dentists, nurses, opticians, and druggists. This work was done at a total cost to the Committee of $2,500, and to date has brought in about 90,000 signatures of the required 312 000 gross.

A new undertaking on the part of the Committee this year was that of exhibiting at the various County Fairs. At the May meeting, the Committee earmarked $1.000 to pay cartage on the exhibits to and from the places where County Fairs were held, and so it was possible, during 1941, to exhibit at 13 County Fairs. This was accomplished primarily through the efforts and coöperation of our Secretary, Doctor George H. Kress. The Committee recommends the approval of this portion of the report. . . .

VICE-SPEAKER ASKEY: Is there a discussion? Doctor Makinson.

Discussion:

DOCTOR MAKINSON: I think the report of this Com-

mittee should be revised and brought up to date. I would like to ask permission to bring Mr. Ben Read, Secretary of the California Public Health League, to the microphone, to fully explain these very recent developments.

VICE-SPEAKER ASKEY: To hear Mr. Read speak requires the unanimous consent of this House. Is there objection to hearing Mr. Ben Read speak as requested by Doctor Makinson? Mr. Read, you are invited to discuss this problem before the House of Delegates. Doctor Makinson will introduce Mr. Read.

DOCTOR MAKINSON: It gives me very great pleasure to present Mr. Ben Read. . . .

MR. BEN READ: As a result of the efforts of the members of the profession, we secured a total of 107,000 signatures. Now, that was considerable less than the figures that were quoted around the room very openly at the Coronado meeting, as some of you will recall. We were going to have several hundred thousand signatures within a few weeks and after several months we secured 107,000 with the efforts of the profession and we thought that was pretty good. We do appreciate your coöperation. The Committee then employed a group of professional circulators to complete the job. It requires 212,117 valid signatures to place this on the ballot. And, we now have in view the required number, that means a gross of around 300,000. And we have those in sight, in fact we have the job completed, as we could file the petition tomorrow, if necessary. However, a few weeks ago the chiropractors in an effort to oppose this brought up a sort of a phony initiative proposition, and they have the title of "Basic Subject Act." It has three or four high school subjects in it, and the entire purpose is to confuse the public and defeat the Basic Science Initiative. Now, they have employed another group of professional solicitors to secure their required signatures. The job must be done in rather short order, as June 5 is the closing date for securing their required number of signatures. We rather doubt if they have any desire to get this before the people and pass it. They simply want to kill your Basic Science Initiative. As one of their methods, you may have noticed that Doctor Kress, in your CALIFORNIA AND WESTERN MEDICINE, reproduced letters sent to all chiropractors in the State, in which they were told to contribute the amount of $100 each, or their license would be endangered by the State Chiropractor Board. . . . So, we are confronted with a campaign of meeting that opposition that is now in the field. I can't, for obvious reasons I believe that you will all understand, give in a public meeting the details of that campaign. The Committee understands it, the Council has approved it, and we are proceeding along the lines that we believe will result in ultimate success. The matter is now in the hands of the Committee, and with the approval of the Executive Committee the outcome will be known within the next few weeks. We are doing the best that we can, to see that the opposition is defeated, and that your wishes are carried through to success. Again we wish to thank all of you for your efforts. A lot of you worked hard. I have one Doctor, who got over 800 names; then, we have others who got none, and some, of course, many. We thank those who coöperated and within a few weeks you will know definitely what the future campaign is. (Applause.)

VICE-SPEAKER ASKEY: Thank you, Mr. Read. Doctor Makinson. . . .

VICE-SPEAKER ASKEY: This question is one of great importance because of the factors involved. My advice to you, and I think the advice of all, would be to look at these letters in the CALIFORNIA AND WESTERN MEDICINE and see what your opposition is ready to do. I think you will then comprehend the importance of this, and I am sure that if we inform ourselves, and follow Ben Read's direction, and after his demands on our time and help, that everything will be well. Now, is the further discussion? If not, all in favor say, "Aye," opposed, "No." It is carried. Dr. O'Neill, will you finish?

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Report of Committee on Physicians' Benevolence:

The Council of the California Medical Association, at its meeting of January 17, 1942, adopted the recommendations of this Committee providing for methods for distributing (a) the appointment of each County Medical Society of Physicians' Benevolence Committee, (b) auditing of the funds, (c) change of the name of this Committee, (d) and other matters required to enable this Committee to function and furnish some measure of relief to our needy. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: This section is adopted.

* * *

Report of the Editorial Board:

It was recommended that, in lieu of publishing all the papers that could be printed in the OFFICIAL JOURNAL or making selection therefrom, henceforth, beginning with this meeting of the California Medical Association, a special edition in the form of a supplement to the California Medical Association JOURNAL be published, in which be included a digest of every paper read at the State meeting. It was recommended that a section of the JOURNAL be set up which would appear from month to month with a review of the latest literature and discoveries in the field of medicine. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: The Chairman moves this section of the report be adopted. Is there a second? Doctor Kneeshaw.

Discussion:

DOCTOR KNEESHAW: Mr. Chairman, I have been informed that Chairman Lee of the Editorial Board who is now in the service, made that suggestion, about abstracts of all annual session papers, as outlined in his Pre-Convention Bulletin report, without consulting the rest of the Executive Committee, and I have been informed that at the annual Board meeting held on Sunday, May 3rd, the Board Members present agreed that the plan could not be carried out in a successful manner. I believe that there should be a deletion of that portion of the report which calls for the special edition, and I move such amendment of that report.

VICE-SPEAKER ASKEY: Is there further discussion? Doctor Walker.

DOCTOR WALKER: Doctor Russell Lee suggested this and there was much discussion at our Sunday meeting, of the plan to publish a digest of one column each, of all the papers read before the Annual Session. It was the concensus of opinion, by all present that while that might be desirable for some reasons, there were other reasons why it was not a practical procedure. The issue would be a hodge-podge of incomplete abstracts. We think it would not work well and for that reason the Editorial Board Members on Sunday last were unanimous in wishing to leave this out.

The other part of the report refers to the contributions to editorials for the Editorial Comment department as mentioned by Doctor Lee. We were all heartily in accord with that.

Then, a desire to have someone abstract from various articles published. That met with favor, if good abstracters could be obtained. Possibly, if each Section could furnish someone to abstract articles concerning the respective Section, it would be highly desirable. Therefore to one part of Doctor Lee's articles we were opposed but to the other two recommendations we were heartily in accord.

VICE-SPEAKER ASKEY: Doctor Wilbur.

DOCTOR WILBUR: As a newly appointed member and Chairman of the Executive Committee of the Editorial Board, I should like to point out certain advantages of this particular method of Doctor Lee's of reporting the proceedings of the papers given at the State meeting. Those of you who are members of certain national associations will recall that special journals reporting those proceedings do print abstracts of all papers usually within a period of a few months after the meeting is held. It is to a great advantage of those who are unable to attend the meeting, or if they are, to hear all the papers given. You will also recall in the *Journal of the American Medical Association* there is published the abstract proceedings of the Central Society for Clinical Research, which proceedings the *Journal of the American Medical Association* considers sufficiently important to publish in that Journal. May I also point to another advantage? And that is by having such a supplementary number of abstracts, it is possible to bring before the profession in a relatively short period of time all the material which is presented before the Scientific Sessions of the State meeting. This will overcome the present situation in which some papers never reach the light of day in the *State Journal* and others require a period of at least eight months or a year before appearing in the JOURNAL. For those authors who wish to make a very brief abstract, this abstract may be included in such a supplement. For those papers which are of particular merit, the Editorial Board can consider whether or not they should be published in full in the JOURNAL. I, therefore, would like to urge that this particular provision of the Committee's report be included and not deleted.

VICE-SPEAKER ASKEY: Is there further discussion on this? Is there an estimate that could be made on this, Doctor Kress?

SECRETARY KRESS: The cost of the JOURNAL is under the jurisdiction of the Executive Secretary, Mr. Hunton. He will be able to give you approximate figures concerning costs. It would depend on the size of the signature or number of extra pages. We print ordinarily in group forms of 4, 8, 16, 32, 64 pages. I think we would need at least a 64-page form to include the abstracts of 150 manuscripts, provided it would be possible to secure such.

VICE-SPEAKER ASKEY: Mr. Hunton, can you be of help to us?

MR. HUNTON: It is impossible to estimate it accurately because of the fact that the composition of mechanical words as a supplement would not be comparable with mechanical words incurred in printing the regular issues of the JOURNAL. It would be my estimate that the supplement would cost in the neighborhood of $1,500.

VICE-SPEAKER ASKEY: Does that answer your question, Doctor? Is there further discussion?

UNIDENTIFIED: Could this supplement be combined with the program so that the abstract would be ahead of the meeting rather than behind? Would that cut down the costs?

VICE-SPEAKER ASKEY: Doctor Kress, could you answer that question? The question is, "Could an abstract be given with the program, the Pre-Convention program, to obviate the necessity for this publication.

SECRETARY KRESS: Mr. Speaker, if you printed in advance, digests of one column length, of all papers read at an annual session, you would take away not only the interest in but value of many papers. Our fifty word abstracts in the Pre-Convention Bulletin permit our members to acquaint themselves in advance of the nature of each paper to be read. But to do more than that prior to the annual session would be detrimental to the best interests of the essayists and the OFFICIAL JOURNAL.

VICE-SPEAKER ASKEY: Is it the understanding of this House that the abstracting and the inclusion of any such material that might be used would still be under the jurisdiction of our Editorial Board. I think that that is quite evident. Is there further discussion? All in favor say, "Aye," opposed, "No." I'll call for a rising vote. All in favor, please stand. The question is on the inclusion of this section of the report, which establishes a special supplement to be issued after the Convention, including abstracts of the papers, and such other abstracts as the Editorial Board shall deem wise. It will be estimated at a cost of about $1,500 or thereabouts. Is there any other question before the question is put? All in favor, please stand. Dr. O'Neill's motion is lost. That section is not adopted.

* * *

Report of the Committee on Local Arrangements:

This beautiful auditorium and lecture rooms in which you are now seated here in Del Monte bespeak the interest and the coöperation shown by the Committee on Scientific Program and Local Arrangaments, and the hotel management. The credit of securing the full coöperation of the Fort Ord military authorities goes largely to Doctor Mast Wolfson of Monterey, Chairman of the Local Committee on Arrangements. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: This section is adopted. (Applause.)

* * *

Report of Delegates to the American Medical Association:

I am sure that the representation from California will always render a favorable account of themselves at the American Medical Association. Cleveland was the host to the American Medical Association in the year 1941. The House of Delegates which is the legislative and governing body of the National Association was in session four days, beginning June 2, 1941. All the members of the California delegation were present and took an active part in the proceedings. The House has twelve Reference Committees. On these, three of the California members were appointed. Our California delegation was requested by the California Medical Association to present the following resolutions:

(1) Resolution requiring appointment of Committee to confer with Committees of hospital associations. (2) Resolution authorizing establishment of a Health Exhibit for the public at cities where annual sessions are held. The first of these was approved and adopted by the House. The second was referred to the Board of Trustees which after consideration, advised that such a plan was not practical, and that such exhibits were usually held in Convention city either prior to or following the Convention week. The highlight of the last A.M.A. session was the report of the Committees on Medical Preparedness and the establishment of the Procurement Agency which later was made a part of the national administration under the honorable Paul V. McNutt. A comprehensive report of the American Medical Association trial was presented to the House of Delegates by the Board of Trustees. It was voted to sustain the action of the Board of Trustees in appealing the verdict of guilty. California was honored in the election of Doctor Charles A. Dukes as Vice-President of the American Medical Association. This was a much deserved honor to our beloved colleague, whose recent passing has given us great sorrow. He had been a member of the House for several years and had endeared himself to all by his never-failing kindly manner, and his earnest devotion to the best in organized medicine. It is with deep regret, therefore, that the California dele-

present to the Alameda County Medical Association the following question, "Will the Members of the Council of the Alameda County Medical Association, on behalf of its membership and for the benefit of medicine and the good of the profession in California, subjugate their personal opinions to the opinion of the majority of their fellows of the California Medical Association and rescind the Resolution above mentioned?"; now, therefore, be it

Resolved, That the answer of the Council of the Alameda County Medical Association, to said question, may be deferred for a period not to exceed thirty days, and within that time the Alameda County Medical Association must submit a definite answer in writing to the foregoing question submitted to it.

Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR MURRAY: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." The motion is adopted.

* * *

Concerning Sacramento Society for Medical Improvement:

DOCTOR GARLAND: In this connection your Reference Committee wishes to recommend that the Council of the California Medical Association take immediate action relative to the Sacramento Society for Medical Improvement, presenting to that Society a question analogous to that presented to the Alameda Medical Society, with the request for an answer within a similar period of time. The Committee respectfully draws attention of the delegates the fact that California Physicians' Service is not a County Society Problem. It is a state-wide State Association Problem, created by an overwhelming vote of the delegates of a previous House. As such, it is the duty of each component society of the State Association to support it in every manner possible until such time as the majority of this House recommends its dissolution. Irrespective of the merits of any program embarked upon by this Association, it is incumbent upon us as delegates and members of the Association to support that program. This is not only the very core of democracy, but it is a fundamental necessity for us as a survival as an independent profession.

Finally, in connection with the program of California Physicians' Service, it is our humble suggestion that the income ceiling for beneficiary members be gradually lowered to a figure substantially below the present maximum. Perhaps, $1,800 per annum for individuals, and that a development of indemnification methods for persons above that income level be explored.

Mr. Speaker, I move the adoption of this section of the report.

DOCTOR HAYES: I second the motion.

SPEAKER GOIN: The motion is seconded by Doctor Hayes. Any discussion? Doctor MacDonald.

DOCTOR MACDONALD: In order to clarify the record, I would like the House of Delegates to know that in Sacramento some time ago, at least two years ago, a resolution was adopted regarding California Physicians' Service. At the request of the Council of the California Medical Association, that resolution was rescinded and at the present time, in Sacramento, there is nothing to prevent any individual member from joining California Physicians' Service.

SPEAKER GOIN: Any further discussion? If not, are you ready for the question? The question is on the adoption of this section of the Committee's report. All in favor say, "Aye," contrary, "No." The "Aye's" seem to have it, the "Aye's" have it, and this section is adopted.

* * *

Concerning Unit Values in California Physicians' Service:

DOCTOR GARLAND: The following addition to the Council Report has been reviewed and the Committee recommends its adoption. A Committee of the Council has studied the question of hospitalization costs, and in connection with which it is believed that certain changes can be made which will result in raising the unit value. Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR HALL: I second the motion.

SPEAKER GOIN: Seconded by Hall. Any discussion? Doctor Crosby of Alameda.

DOCTOR CROSBY: I would like to tell you two stories....

Now, there have been certain repercussions concerning medical service, gentlemen, that have caused a great deal of trouble, a great deal of anxiety and a great deal of friction, and a great deal of acrimony in the California Medical Association, and the difficulty lies in this: that people are paying too much attention to the repercussions and are not paying attention enough to the circumstances that laid the foundation for those repercussions. This change in the ceiling income of beneficiary members is a perfectly beautiful gesture, and it may help, but I think we have got to remember that we can't give too much attention to repercussions, and we have got to retrace a little bit and give our attention to the circumstances that are causing the actions that are producing those repercussions. (Applause.)

SPEAKER GOIN: Any further discussion? Doctor Lawson of Oakland.

Discussion:

DOCTOR LAWSON: I am speaking as a representative of one of the hospitalization organizations operating in California, the Hospital Service of California, with headquarters in Oakland, to give you one or two figures about hospitalization costs in the last three to five years. In the Guild Index of New York City which analyzes the hospital costs of all the hospitals in the United States, it is stated that from January 1, 1939 to January 1, 1942, the costs of the hospitals, as regards materials and supplies, have risen 35 per cent. As far as salaries are concerned, they have risen 10 per cent—a total cost of 45 per cent in the last two years. There is on foot in Washington legislative, a bill to deny taxation exemptions for all hospitals, both non-profit, or for profit, and, also to put an income tax on all hospitals and colleges. Also, we have a movement at Washington to include all hospital employees as far as Social Security taxes are concerned, which will mean an increase of 5 per cent of hospital employees' salaries and the employers to add 5 per cent. Your President-elect, Doctor Karl Schaupp, is a member of our Board of Directors and he has told very tritely what the hospitals do when this subject of hospital costs comes up. . . . At the present time, we must realize that respecting the hospitalization costs in the entire United States, they are the highest right here in California and the highest are in Alameda County. Our ward bed costs go from $5.50, most $6.00, and up, with the emphasis on the up, and if you think we are well organized, don't think we are as near well organized as are the hospital associations. They are telling us, gentlemen, where to head in. Practically, they say: "Take it or leave it. Our beds are occupied. We don't have to do as you say." The hospitals are telling the medical profession what to do. As far as hospitals being willing to take certain suggestions at the present time, with a boom on, they won't listen a second time. . . .

SPEAKER GOIN: Any further discussion? Question is on the adoption of this section of the report. All ready for the question? All in favor say, "Aye," contrary, "No." The "Aye's" have it. The section is adopted.

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DOCTOR GARLAND: Part No. 2: *Report on the Secretary-Treasurer:*

The Committee recommends the adoption of the report

gation will have to return to Atlantic City without the cheerful companionship of Doctor Dukes. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: The section of the report is adopted.

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Reports of the Committee on Scientific Work and Secition Secretaries:

The tentative scientific program outlined last summer by the California Medical Association Committee on Scientific Work and Section Secretaries underwent a radical change with the onset of war in December. It was then decided that military medicine and surgery should be stressed, and in order to conserve time of members, the general and section meetings on Thursdays would be omitted. An additional general meeting was secured for the allocation for Tuesday afternoon for that purpose. The military features of a program will be emphasized by the exhibit of the First Medical Regiment of the United States Army obtained through the coöperation of the medical officers at Fort Ord. All members in attendance should visit the tents which will bet set up adjacent to the Convention Pavilion. The Committee recommends the adoption of this section of the report.

VICE-SPEAKER ASKEY: This section is adopted.

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DOCTOR O'NEILL: At this evening's meeting, a report was handed to me by Doctor Garland on the *Committee on Medical Defense.*

VICE-SPEAKER ASKEY: If it is part of a report to your Committee, it is submissible.

DOCTOR O'NEILL: It is a part of a report to our Committee. Committee on Medical Defense. The Committee on Medical Defense did not render a formal report in the Pre-Convention Bulletin. However, members have brought to our attention the following information, much of which has appeared already in the Bulletin of the Los Angeles County Medical Association. The report concerns:

(1) The experience of insurance companies in the medical mal practice field has been poor.

(2) It is desirable that support be given to any American company of adequate size, stability, and experience, furnishing approved policies is this field.

(3) Such a company is operating in some parts of the State. The essentials of this program are the

(a) careful selection of risks, confined to members of the organized medical profession,

(b) handling of claims by the carrier in coöperation with the Committee on Medical Defense, and

(c) maintenance of records available to the medical profession for purposes of annual review, permitting determination of equity of premium charges. Your Committee recommends the approval of this report.

VICE-SPEAKER ASKEY: What is this report? Is it just a report to this body that there is available other insurance? Did you wish to speak, Doctor Garland? . . .

Discussion:

DOCTOR GARLAND: Mr. Speaker and Members: Doctor Nelson Howard asked me to prepare a thumb tack of a report dealing with this question, because he could not be here. He is the Chairman on the Standing Committee on Medical Defense. Now, this report represents the best opinion of Doctor Howard on this problem. It is not a recommendation of any one particular thing. It is just bringing your attention to certain facts which he believes are correct. I tried to get hold of the Reference Committee in question, so that this might be incorporated, in proper orthodox manner, in his report, but I couldn't find the Committee until tonight at 5 o'clock and that is why it was brought out in this slightly irregular manner.

DOCTOR CLINE: I believe that this is correctly in the hands of the Committee, because it is merely a report and not a resolution. There seems to have been a little confusion concerning Doctor Howard's wishes in this matter. Apparently, Doctor Garland understood him one way. I understood him another way quite completely. This matter was presented for inquiry before the Council in my behalf the other day, and certain information came out as a result of the discussion at that time, which I think would make Doctor Howard's mind up in a different way than expressed in the report.

DOCTOR WILSON: I offer an amendment that the report be filed.

VICE-SPEAKER ASKEY: You have the motion to amend the motion so that the report be filed. Is there discussion on the amendment? All in favor of the amendment, which is to file this section of the report say, "Aye," opposed, "No." The amendment is carried. The motion is now before you. All in favor of the motion as amended say, "Aye," opposed, "No." The motion as amended is adopted and this will be filed.

DOCTOR O'NEILL: Mr. Speaker, I move that my report as amended be approved.

DOCTOR FLETCHER: I second the motion.

VICE-SPEAKER ASKEY: Doctor Alesen.

DOCTOR ALESEN: Do I understand, sir, that the special report of our Council dealing with bureaus and commissions, and pointing out pernicious effect before our economic body, is also included?

VICE-SPEAKER ASKEY: Was that in your report, Doctor O'Neill?

DOCTOR O'NEILL: That was not in my report.

VICE-SPEAKER ASKEY: . . . Question is on the adoption of the Report of Reference Committee No. 1, as presented by the Chairman, as amended and as a whole. Is there further discussion? All in favor of the adoption of the Report of Reference Committee No. 1, as amended say, "Aye," opposed, "No." The report is adopted.

At this time I wish to state to you, as you all know that I have been your Chairman by the kind indulgence of your real Speaker, that at this time I will return to him the gavel. (Applause.)

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REPORT OF REFERENCE COMMITTEE NO. 2

SPEAKER GOIN: Reference Committee No. 2 for the purpose of receiving the report of that Committee, the Chair recognizes its Chairman, Doctor L. Henry Garland, of San Francisco.

DOCTOR GARLAND: Mr. Speaker and Members of the House: I have a very slim report to present to you:

The Report of the Council:

(a) as printed in the Pre-Convention Bulletin. The Committee has reviewed this report and recommends its adoption. . . . The motion is carried.

DOCTOR GARLAND: (b) the *Additions to the Report of the Council* as presented to the first session of the House,* the following addition has been reviewed and the Committee recommends its adoption:

Concerning C.P.S. Resolution of Council of Alameda County Medical Association:

WHEREAS, The Council of the Alameda County Medical Association has by Resolution advised the Members of said Association to resign as professional Members of the California Physicians' Service; and

WHEREAS, The Council of the California Medical Association, at a meeting held May 3, 1942, duly resolved to

* See New Item 1 on page 61.

of Delegates. The substituted report reads as follows:

This is a report of the Committee delegated by the President of the California Medical Association to investigate the advisability of seeking an increase in the Industrial Accident Fee Schedule in pursuant to a resolution introduced at the 1941 House of Delegates by the Alameda County Medical Association.

After careful consideration of the various factors involved, and with the advice of the Council of the California Medical Association, your Committee wishes to submit the following report and make the recommendations suggested below:

1. That the Industrial Accident Fee Schedule be increased, as follows:

(a) That hospital, office, and home visits be increased 50 per cent.

(b) That all other fees, either listed on the schedule or unlisted, be increased 25 per cent.

2. Your Committee feels that it is inadvisable to establish separate specialty schedules, such as have been requested by the various specialty groups.

3. Your Committee agrees that there are many abuses and shortcomings in the administration of Industrial Fee Schedules, but believes that these difficulties should be considered separately from the Fee Schedule itself.

4. Your Committee recommends that the above suggestions be placed before the Industrial Accident Commission for action.

Respectfully submitted,
MORTON R. GIBBONS, M. D., *Chairman*
FRANK A. MACDONALD, M. D.
CARL L. HOAG, M. D.

Your Reference Committee approves the report of this Special Committee, and further suggests that in carrying out the recommendations of this Special Committee on the California Industrial Accident Commission Fee Schedules, the Council of the California Medical Association appoint a Committee to place the recommendations of this Special Committee on California Industrial Accident Commission Fee Schedules before the California Industrial Accident Commission. As Chairman, I move the adoption of this report.

DOCTOR GREEN: I second the motion.

SPEAKER GOIN: Any discussion? Doctor Cass of Los Angeles.

Discussion:

DOCTOR CASS: The question of increasing Industrial Accident Fee Schedule has been one that the section of the Standing Committee on Industrial Practice has had in consideration for several years, and a satisfactory working out of this problem has been very difficult because, in the first place, the Industrial Accident Commission is not in the least bit interested in increasing doctors' fees. They are interested in their own job, and it is up to the doctors to get this increase in fees in a different way than by just asking the Commission. My purpose in coming up here now is to state that I believe in a plan by which this report could be amended so that a Fee Schedule be prepared by this Committee, approved by the Council of California Medical Association, and adopted by the House of Delegates as a fair Industrial Accident Fee Schedule and be submitted to the Industrial Accident Commission, and also be submitted to our own members in such a way that it would be more or less obligatory on our members to accept this Fee Schedule. Now, this carries with it a lot of side work which is difficult to comprehend in one motion; such as, the penalties that we will accrue if these Fee Schedules are not adhered to. That is a very difficult problem, because we all know that irregular practitioners will do the work for less money than we if we put our Fee Schedule too high.

I would like to suggest, as an amendment to the report, that a substantial, fairly complete Fee Schedule be prepared by this Committee rather than just an arbitrary percentage of increase in fees.

SPEAKER GOIN: Do I hear a second to the amendment?

DOCTOR KNEESHAW: I second the amendment.

SPEAKER GOIN: Is there discussion? Question is on the adoption of the amendment proposed by Doctor Cass. Any discussion? All in favor say, "Aye," contrary, "No." The "Aye's" seem to have it. The "Aye's" have it. The question is on the adoption of this section of the report as amended. All in favor say, "Aye," contrary, "No." This section is amended.

* * *

Report of Committee on Medical Preparedness:

This Special Committee, of which Doctor Harold A. Fletcher is Chairman, has presented an excellent report, which your Reference Committee approves. It is also the feeling of your Reference Committee that the Committee on Medical Preparedness, and particularly its Chairman, Doctor Philip K. Gilman and his successor, Doctor Harold A. Fletcher, have done in a highly commendable fashion, a tiresome and thankless job, which should meet with the commendation of all of the members of this House of Delegates and the California Medical Association. As Chairman, I move the adoption of this section of the report.

DOCTOR PALLETTE: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." It is carried.

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Report of the Legal Department:

Your Committee reviewed the report of the Legal Department, which it approves. As Chairman, I move the adoption of this section of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? Doctor Alesen.

Discussion:

DOCTOR ALESEN: Mr. Speaker, this is an excellent report. I feel that it may be buried in the archives, without due notice being taken of it unless something is done at this particular time. I want to read one imposing and particularly interesting and instructive paragraph.

The profession has been facing the legislative thinking in terms of legislative action. It has been prepared to defend itself against legislative attack and it has successfully done so. But, while the profession is furnishing a legislative front, and thinking in terms of legislation, an entirely different attack is being planned and executed by a different branch of government; namely, the executive or administrative branch. If the profession wheels about and faces the administrative threat, it may suddenly find itself defeated from the rear, while it has had its guns trained on the front.

Mr. Speaker, I move an amendment to this report:

(1) That the House of Delegates commend the Legal Department for this excellent report;

(2) That the Central Office be instructed to reprint these essential parts and to send a copy of this report to every member of the California Medical Association and every member of the Dental Societies in this State.

SPEAKER GOIN: Seconded by Doctor Bailey. Any discussion? Doctor Ayres of Los Angeles.

DOCTOR AYRES: This is rather a small thing to take issue with and I certainly think that the Legal Department deserves all of the support and approbation that we can give it. But, I just want to call attention to the fact, in passing, that the serious and hidden dangers of Governmental Bureaus and so forth merely mean that changes in conditions require changes in the functions of Government, and that one of the ferocious bureaus that

as printed, and in doing so it wishes to draw your attention the sound condition of the finances of the California Medical Association. It discloses the combined surplus as of December 31, 1941 as $92,578.12. Some of this will, of course, be expended on the Basic Science Initiative during the current year. Further, our income has diminished considerably as a result of the remission of dues to members in the military service. In connection with future Reports of the Treasurer: the Committee respectfully suggests that these be simplified, and perhaps not reproduced entirely in the formidable manner customary with certified public accountants. Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? If not, all in favor say, "Aye," contrary, "No." The motion is carried.

DOCTOR GARLAND: Part No. 3: *Report of the Executive Secretary:*

The Committee recommends the adoption of the report, as printed. Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." The motion is carried.

DOCTOR GARLAND: Mr. Speaker, I now move the adoption of the entire report. Motion is carried.

SPEAKER GOIN: . . . Reference Committee No. 3 is the Committee on Resolutions, Amendments of the Constitution and By-Laws, and Miscellaneous Business, with Doctor Dwight L. Wilbur, as Chairman.

CHAIRMAN WILBUR: May I ask, since this report is longer than that of the Chairman of the last Committee, that the House recess for a moment while mimeographed copies of our report are distributed among the members of the House. . . .

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REPORT OF REFERENCE COMMITTEE NO. 3

CHAIRMAN WILBUR: Mr. Speaker, Members of the House of Delegates:

The members of this Reference Committee No. 3 are Doctors Dwight H. Murray, delegate of Napa County; Franklin Farman, delegate of Los Angeles County, and myself, of San Francisco County. Reference Committee No. 3 has met and had hearings on the proposed amendments to the Constitution, a proposed amendment to the By-Laws, Resolutions, Reports of Special Committees, and the Report of the Legal Department and wishes to report to you as follows:

(a) *Report of the Committee on Payments for Medical Services:*

It was reported that no amendment will be suggested, Mr. Peart, as legal counsel having informed the Committee that such could not lawfully be done. Your Committee approves the recommendation, and as Chairman, I move the adoption of this section of the report.

DOCTOR O'NEILL: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." This section of the report is adopted.

Report of the Committee to Survey California Medical Association Legal Department:

Regarding the verbal report given by Doctor Gilman, as Chairman of the special committee to survey California Medical Association Legal Department, the Reference Committee wishes to report that the House of Delegates having been informed that the survey of the Legal Department has been made with findings satisfactory to the Council, the Reference Committee recommends approval by the House of Delegates. I hereby move adoption of this section of the report. . . . This section is adopted.

Report of Committee on Conference with California State Federation of Labor:

Regarding the report of the Committee on Conference with California State Federation of Labor, the Reference Committee wishes to report that the House of Delegates, having received an oral report by the Chairman, Doctor Cline, recommends that this Committee be continued to carry on its further duties and work. I move the adoption of this section of the report. . . . This section is adopted.

Report of the Committee on Pension Policy for Retired Employees:

A report of the Special Committee on Pension Policy for Retired Employees, prepared by Doctor Edward N. Ewer, Chairman, was submitted to your Reference Committee as a report to substitute for the one presented to the House of Delegates which substituted report reads as follows:

"In the matter of pensioning employees of the California Medical Association, your Committee recommends that the Council of the California Medical Association be authorized and directed to take such action as they may deem advisable from time to time." Your Committee approves this report. As Chairman, I move the adoption of the substituted report.

DOCTOR KIGER: I second the motion.

SPEAKER GOIN: The adoption of this section of the report and authorization of the Committee to carry out the policy it sees fit in regard to pensioning employees is moved. Any discussion? All in favor say, "Aye," contrary, "No." This section is adopted.

Report of Committee on Hospitalization Subsidy:

The Committee on Hospitalization Subsidy, of which Doctor John Hunt Shephard is Chairman, has filed a progress report with the House of Delegates, in which it is pointed out:

(1) that a final legal opinion on the legality of hospitalization subsidy had not been secured;

(2) that various members of the State Legislature, when interviewed were opposed to any action at this time that would require any new or shifting of tax burden; and

(3) that on account of increased wages and decreased unemployment during the past year, many doctors are less interested than previously in any change in the ways and means of payment for medical costs. This Special Committee was, therefore, not prepared to submit a comprehensive report at this time.

Your Reference Committee has reviewed this report and wishes to call to the attention of the House of Delegates the fact that the American Medical Association opposes the principle of hospitalization subsidy, and it, therefore, feels that any effort in behalf of State or Federal hospitalization subsidy be not approved. As Chairman, I move the adoption of this section of the report.

DOCTOR HOPE: I second the motion.

SPEAKER GOIN: Your adoption of this is in concordance with your action in supporting the amendment proposed by Doctor Halley in the other Committee report. Is there any discussion? All in favor say, "Aye," contrary, "No." Carried. This section is adopted.

Report of Committee on California Industrial Accident Commission Fee Schedules:

This Committee, of which Doctor Morton R. Gibbons is Chairman, has submitted to your Reference Committee a report to substitute for the one presented to the House

we are all hollering about is the Procurement and Assignment Service, which is a Governmental Bureau, and which, it seems to me, far from working in direct opposition to the practice of medicine, has shown 100 per cent coöperation through the American Medical Association. Another one of these monstrous bureaus with which the Government is threatening to impose socialized medicine upon the medical profession is the Defense Housing Project, which coöperated 100 per cent with the medical profession through California Physicians' Service in the rendering of medical care to people coming under that assignment. Other Bureaus could be cited such as the Farm Security Administration in which again the Government has shown an interest and a desire to coöperate with the medical profession, and I just simply raise my voice to call attention to these facts. Now, if it desired to pass this amendment, and spend the extra money in sending out this rather interesting epistle to all of the members of medical and dental professions, so be it.

SPEAKER GOIN: Any further discussion? The question is on the adoption of the amendment. Are you ready for the question? All in favor say, "Aye," contrary, "No." The Chair is in doubt. Will those voting "Aye" please rise? Be seated, gentlemen. The vote is 46 for the amendment and 42 against. Therefore, it is carried. The question is now on the adoption of the report as amended. Are you ready for the question? All in favor say, "Aye," contrary, "No." It is carried.

* * *

Report of Physicians' Benevolence Committee:

Mr. Speaker, may I ask that in view of the fact that this report is printed and in the hands of all of the delegates, and since the hour is late, may I proceed without reading the report of this Committee.

SPEAKER GOIN: I think you may read the Committee's conclusions and recommendations.

DOCTOR WILBUR: Your Reference Committee considered the report of the Physicians' Benevolence Committee in two parts:

(1) The first part of the report deals with the care and disbursement of aid to our needy members; and

(2) The second part deals with the suggested amendment to the by-laws.

(a) Your Committee, after having considered this carefully, approves of the first part of the report, dealing with the care and disbursement of aid to our needy members, and as Chairman, I move adoption of this section of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." Carried.

DOCTOR WILBUR:

(b) Inasmuch as the second part of the report deals with an amendment to the by-laws, and since this amendment is to be considered separately and subsequent to the Committee Report, we request that the vote on the second part of the report be withheld until after the vote on the amendment to the by-law has been taken.

* * *

(c) *Proposed Amendment to the By-laws No. 1—Concerning Physicians' Benevolence Committee:*

May I ask again, Mr. Speaker, if we can delete reading of this proposed amendment which has been published in the Pre-Convention Bulletin, and is also in the hands of each member of the House.

SPEAKER GOIN: Yes, would the House like Mr. Peart again to say briefly what the purpose of this amendment is? It is very involved in its phraseology.

DOCTOR WILBUR: May I say one word in that respect, Mr. Speaker? The Reference Committee has prepared a substitute to this amendment which is very brief. In view of the presentation of this substitute amendment possibly you would like to hear it, and not the proposed amendment which was published a year ago and again in the Pre-Convention Bulletin.

SPEAKER GOIN: That is wise.

DOCTOR WILBUR: The Reference Committee is of the opinion that the proposed by-law amendment No. 1 is not correct in policy, and will not be workable and satisfactory over a long period of time, for the following reasons:

1. The Reference Committee feels that the allocation of $1.00 per year per member from the dues of the California Medical Association would, before long, lead to the accumulation of a considerable sum of money;

2. To allocate this fund to the control of a separate committee of the California Medical Association would lead to decentralization of our funds, and might set a precedent for doing so with other committees, thereby removing control of funds of California Medical Association from the Council of the California Medical Association, where it rightfully belongs.

The Reference Committee recommends that the proposed amendment No. 1 to the by-laws be not adopted. I hereby move adoption of this section of the report.

DOCTOR CLINE: I second the motion.

SPEAKER GOIN: The adoption of this section of the report will have the effect of defeating the amendment which is published here. Are you ready for the question? All in favor say, "Aye," contrary, "No." It is carried.

DOCTOR WILBUR: The Reference Committee does, however, offer a substitute amendment to the by-laws reading as follows:

Substitute Amendment to By-laws:

(d) *Resolved,* That Section 23 of Chapter V, of the By-laws of this Association, California Medical Association, be and the same hereby is amended by deleting the words, "Committee on Aid to Needy Members," from the title and the body of said section wherever said words appear, and substituting therefor the words, "Physicians' Benevolence Committee," and by deleting from said section the words, "Special Fund for Aid to Needy Members" wherever the said words appear and substituting therefor the words "Physicians' Benevolence Fund."

The foregoing substituted amendment merely changes the name of the Committe, in accordance with the Committee's request, and I, therefore, hereby move the adoption of said substitute amendment.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." Carried.

DOCTOR WILBUR: The Reference Committee also recommends:

(e) That the House of Delegates instruct the Physicians' Benevolence Committee to submit in each year to the Council of the California Medical Association a budget which is estimated will be sufficient to take care of our needy members for the ensuing year.

It is further recommended that the Council be instructed to be generous and liberal with appropriations for the care of these needy members. I move the adoption of this section of the report.

DOCTOR DOYLE: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." Carried.

* * *

Donation to Physicians' Benevolence Fund by Woman's Auxiliary:

DOCTOR WILBUR: In this connection, Mr. Speaker, I should like to state:

(f) That the Woman's Auxiliary of the California Medical Association has presented to the Benevolence

Fund of the California Medical Association, or will present on May 15, a check for $735 for the use of the Physicians' Benevolence Committee. May I ask, perhaps out of order, that the House of Delegates, by a vote of thanks to the Woman's Auxiliary, express thanks for this gift.

SPEAKER GOIN: We will ask the House to rise in an expression of a vote of thanks. (House rose.)

* * *

Concerning Proposed Amendment Relating to Physicians' Benevolence Fund:

DOCTOR WILBUR: To return now to the final part of the report of the Physicians' Benevolence Committee:

(g) Following consideration by the House of Delegates of the proposed amendment to the By-laws No. 1, the Reference Committee wishes to present for consideration the second portion of the report of the Physicians' Benevolence Committee. It is the recommendation of the Reference Committee that this portion of the report dealing with a proposed amendment to the by-laws, allocating a portion of the dues of members of the California Medical Association for use by the Physicians' Benevolence Committee, be not accepted. I move the adoption of this section of the report.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." This section of the report is adopted.

* * *

DOCTOR WILBUR: *Your Reference Committee on Medical Service Rendered by Hospital Associations* submits the following report:

The statement of policy, adopted by the Council of the California Medical Association on October 26, 1941, expresses very clearly the position of the medical profession, and should be reiterated at this time and officially adopted by the House of Delegates.

The California Medical Association has consistently endorsed the principles of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give and it never has given approval to any contracts which provide medical benefits or services as a part of hospital services. It does not object to the provision of limited diagnostic medical services (x-ray and laboratory), along with hospital benefits, provided that these are arranged for on some ethical and legal basis, such as reimbursement or indemnification.

Your Committee feels that the officers and Council of the California Medical Association should use every effort to have all Hospital Associations operating in California carry out the above policy, both in spirit and in letter.

The Reference Committee has reviewed the report of the Committee on Medical Services Rendered by Hospital Associations, and recommends adoption of it. I hereby recommend the adoption of this section of the report.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." This section is adopted. Doctor Wilbur, on the proposed amendment regarding dues of members in military service, don't you think you might go to where you explain the essence of the amendment. They have all had it.

* * *

Re: Proposed Amendment No. 1 to Constitution.—State Association Dues of Members in Military Service. Adopted

DOCTOR WILBUR: In relationship to proposed amendment No. 1, may I, at the suggestion of the Speaker, read the conclusions of the Committee. The essence of this amendment is that annual dues may be reduced or waived with respect to those members serving in the Armed Forces of the United States. The Committee is unanimous in its approval of this amendment, and I, as Chairman, therefore, move the adoption of this amendment. It has been printed twice on this sheet with minor changes made with the aid of our legal counsel. These changes were made to clarify the meaning of this Constitutional Amendment by the insertion of the words, "dues for any part of any year," so that there will be no misunderstanding as to whether the years be 1940 or 1941. So that the dues of members may be waived for any part of any years that they are in the Armed Forces of the United States. I, therefore, as Chairman of the Committee, recommend the adoption of this Constitutional Amendment as modified.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Is the House content to waive complete reading of this? Doctor Wilbur has given you the essence of it. The long phraseology is merely to make clear what is to be done. Ready for the question? All in favor say, "Aye," contrary, "No." The amendment is adopted.

* * *

Re: Proposed Amendment No. 2 to Constitution.—On Manner in Which State Association Funds May Be Raised. Adopted

DOCTOR WILBUR: In regard to *Proposed Amendment No. 2,* which has been published in the Pre-Convention Bulletin and again is available for you here. Mr. Speaker, may I delete reading this Constitutional amendment and come to the report.

This proposed amendment states in brief those *Ways in Which Funds May Be Raised by the California Medical Association,* and has, as its principal addition, a clause stating that, "In the event that the House of Delegates levies any special or other assessment other than the annual assessment of dues, it may, in the resolution levying the assessment, fix and determine the time within which such assessment must be paid, the class or classes of members of the Association upon whom it is levied, and the penalty, if any, including forfeiture or suspension of membership in this Association, or the component County Medical Society, or both, to result from non-payment thereof within the time prescribed." Your Reference Committee has considered this amendment, and has unanimously approved of it. I, as Chairman, therefore, move the adoption of this section of the report, rather, Constitutional amendment.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Is the House content to waive the entire reading of the amendment? Are you ready for the question? All in favor say, "Aye," contrary, "No." The amendment is adopted.

* * *

Re: Proposed Amendment No. 3 to Constitution.—On Terms of Office of Speaker and Vice-Speaker. Not Adopted.

DOCTOR WILBUR: Proposed Amendment No. 3. *A Proposed Amendment for Three-Year Terms for the Speaker and Vice-Speaker of the House of Delegates:*

Resolved, That Section 3 of Article X of the Constitution of the Association, the California Medical Association be, and the same is hereby amended, by deleting from said section the words, "for the term of one year," and inserting, in lieu therefor the following, "for a term of three years," so the said section shall hereafter read as follows:

"Section 3. Term of Office. The House of Delegates shall, at the regular annual session thereof, elect a Speaker of the House of Delegates and a Vice-Speaker of the House of Delegates, each to serve a term of three years, or until their successors are elected and assume office. The Speaker and Vice-Speaker shall be members of the House of Delegates at the time of their election."

The Reference Committee wishes to point out to the House of Delegates certain advantages and disadvantages of this amendment.

The advantages are that, to efficiently fulfill this office, requires experience and ability not equally possessed by all members of the California Medical Association. We recognize that the experience gained in having acted as Speaker of the House for one year or more helps to expedite the efficiency of the handling of the proceedings of the House of Delegates, and knowledge so gained is invaluable in the handling of any controversial measures coming before the House.

The disadvantages are that if, by chance, a member of the House of Delegates should be elected to this important office, and should not possess the skill and ability to deal with the duties of the Speaker of the House of Delegates, it is obvious that a change might be desired before his term of office expires.

If, after the experience of one year, the Speaker of the House of Delegates has been found efficient and capable of handling his duties, he may be reëlected annually for as many years as the delegates see fit.

The accepted qualifications of the present occupant of the office of Speaker of the House of Delegates, and his unanimous election to this office year after year, is a persuasive argument for the present method of electing the Speaker of the House of Delegates. However, the Committee submits the proposed amendment without recommendation for determination by the House of Delegates itself.

SPEAKER GOIN: The Chair will entertain a motion on the amendment. Doctor Doughty of San Joaquin.

DOCTOR DOUGHTY: I move that we adopt the report.

SPEAKER GOIN: A motion will have to be made to adopt the amendment.

DOCTOR DOUGHTY: I move the adoption of the amendment.

DOCTOR HALLEY: I second the motion.

SPEAKER GOIN: The amendment is to provide a three-year term for the Speaker and Vice-Speaker. The way to deal with it, is to move that we adopt it, and then to adopt the report. Any discussion? Doctor Ruddock.

Discussion:

DOCTOR RUDDOCK: I would like to speak against this amendment. I wish it were possible to have a man like Doctor Goin as Speaker and have him forever. But, it is possible that some man may be elected whom we don't want, and we may have him for three years. It is the most important office, I believe, that this House of Delegates can offer to any of its members. If we had a bad man up here, he may be able to take a load off these Reference Committees and steer things through this House of Delegates which we would not want at all. I, therefore, speak against this, and I might say that we had a caucus of the delegates of Los Angeles, Orange, Riverside, I think San Bernardino, and we went in caucus unanimously against this amendment.

SPEAKER GOIN: Any further discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." The amendment is lost.

* * *

Re: Proposed Amendment No. 4 to Constitution.—On Authority of Council to Contract with Hotel Managements. Adopted

DOCTOR WILBUR: In regard to *Proposed Amendment No. 4*, may I suggest that since it has been published previously that it be not read at this moment.

The Reference Committee recommends the insertion of the word "five" for the number fixing the number of consecutive annual sessions to be held according to this amendment. I move the adoption of this amendment.

DOCTOR SHARPE, Monterey: I second the motion.

SPEAKER GOIN: Is there any discussion? All in favor say, "Aye," contrary, "No." The amendment is carried.

DOCTOR WILBUR: At this point this Committee would like to read a communication from the California Physicians' Service. The Reference Committee has had referred to it the following letter:

(LETTER)

San Francisco, May 5, 1942.

Dr. Philip K. Gilman,
Chairman of the C.M.A. Council.
Dear Doctor Gilman:

At the meeting of the Administrative Members of California Physicians' Service, held at Del Monte on Tuesday, May 5, 1942, the following resolution was unanimously approved:

Resolved, That the Secretary be requested to communicate with the House of Delegates of the California Medical Association, asking that the liaison committees that were appointed last year be continued, and urging that they function more enthusiastically, to the end that the problems and the status of California Physicians' Service may be better known to the membership at large.

Very sincerely,
A. E. LARSEN, M. D., *Secretary.*

The Reference Committee heartily endorses the content of this letter.

* * *

Re: Industrial Accident Code.—Objectionable Practices

DOCTOR WILBUR: *Resolution No. 1. This Resolution, introduced by Samuel Ayres, Jr.*, Chairman of the Legislative Committee of the Los Angeles County Medical Association, reads as follows: . . . Mr. Speaker, since this resolution was read at the previous meeting, may I read the conclusions of the Committee.

Your Reference Committee has discussed the content of this resolution, particularly the fact that its content is expressed in general terms, and it is felt that these general terms are advisable in that they permit considerable latitude in the manner in which the Committee on Public Policy and Legislation of the California Medical Association may prepare or approve suitable amendments to the Industrial Accident Code, the same to eliminate objectionable practices and abuses which have occurred in the past in relationship to compensation insurance practice. The Committee unanimously approves this resolution, and I, therefore, move its adoption.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? All in favor of the adoption say, "Aye," contrary, "No." The amendment is adopted.

* * *

Re: Un-American Activities

DOCTOR WILBUR: *Resolution No. 2. Un-American Activities.*

This resolution, the purpose of which is self-explanatory, was introduced by Doctor H. R. Madeley of Solano County. May I, Mr. Speaker, read the conclusions of the Committee?

In order to simplify the content but not modify the meaning of this resolution, the Reference Committee wishes to present in its place the following *Substitute Resolution:*

WHEREAS, The Members of the Medical Profession are, and have been since the formation of the Republic, loyal, patriotic citizens; and

WHEREAS, In time of peace and in time of war, the members of our profession have devoted their energies, their material resources and, when occasion has demanded, their lives for the protection of the lives and

property of their fellow citizens, and for the preservation of the American way of life; and

WHEREAS, There may be within the State of California a few members of the Medical Profession duly licensed to practice the healing art who are disloyal to our country; and

WHEREAS, It is the opinion of the members of the House of Delegates here assembled that medical practitioners guilty of such conduct should no longer be allowed to legally practice the healing art in the State of California; now, therefor, be it

***Resolved,* That the House of Delegates of the California Medical Association, in Convention duly assembled, does hereby instruct the members of the Committee on Public Policy and Legislation, and the General Counsel of the Association, to consult with the members of the Board of Examiners and such other bodies as they may deem wise, to the end that enabling legislation be introduced at the next session of the California Legislature which will make the establishment of such disloyal conduct, by the duly constituted authorities, cause for the revocation of the license to practice medicine held by those guilty of such un-American activities.**

I move the adoption of this Substitute resolution.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Is there any discussion? Doctor Ferrier of Los Angeles County.

DOCTOR FERRIER: I think that the Society here is taking a hand in something that it isn't called on to undertake, because the Federal Government is well prepared to look after these cases and to take action, and if persons are proved guilty of treason, they are automatically taken care of under the present law.

DOCTOR DOUGHTY: I move that this resolution be tabled.

DOCTOR ALESEN: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." The Chair is in doubt. Will those voting "Yes" stand? Motion is carried.

Re: Democracy in Organized Medicine

DOCTOR WILBUR: *Resolution No. 3. Democracy in Organized Medicine:*

This resolution, presented by Doctor Russell Fletcher of San Francisco, is self-explanatory, and your Committee unanimously approves of the resolution as of particular merit at such a time when democratic institutions are being threatened from within as well as from without. The resolution reads as follows: . . .

Since this resolution has been read before the House and is here in your hands now, may I ask, Mr. Speaker, that it not be necessary to read this again. I move the adoption of this resolution.

DOCTOR WARD, San Francisco: I second the motion.

SPEAKER GOIN: Is there any discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." The motion is adopted.

DOCTOR WILBUR: *Resolution No. 4. Resolution Regarding Improvement of Relations Between Physicians and Insurance Companies:*

This resolution, introduced by Doctor L. Henry Garland of San Francisco, has to do with defining, clearly, differences between services rendered by hospitals and by doctors, so that there may be no misunderstanding by patients, hospitals, physicians or insurance companies as to whether or not payments rendered to hospitals are for hospital or for professional medical care. The resolution reads as follows: . . .

And Mr. Speaker, since this resolution has been read already, may I dispense with reading it? Your Reference Committee unanimously approves this resolution and I, therefore, as Chairman, move the adoption of this resolution.

DOCTOR WARD: I second the motion.

SPEAKER GOIN: If any member objects to passing over these resolutions, without reading them, he has a privilege of saying so. Hearing no objection, I assume there is none. Is there any discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." This amendment is adopted.

Re: Rebating and Unethical Practices

DOCTOR WILBUR: *Resolution No. 5. A Resolution Regarding Ethical Practices—Regarding Rebating and Unethical Practice of Referring Patients to Commercial Organizations, etc.:*

This resolution, introduced by Doctor Wilbur Bailey of Los Angeles, is as follows in the printed form.

The Reference Committee, after consideration of the resolution, wishes to modify the last paragraph of it, and supplement it so that the substituted resolution reads as follows. If you do not wish to have me read all of the resolution, I should like to read that part which the Committee has modified:

***Resolved,* That it be declared unethical for the Members of the California Medical Association or its component branches, to refer patients to commercial organizations, laboratories, or other physicians who advertise to the public and others than the medical profession, who employ steerers or cappers, or who offer to pay rebates or commissions or in any other manner, violate the Code of Ethics of the American Medical Association or its component branches; and be it further**

***Resolved,* That any physician violating this resolution be subject to whatever disciplinary action is deemed advisable by the County Society of which he is a member.**

In considering this resolution, the Reference Committee has knowledge that the following action was taken at the Council of the California Medical Association at its 302nd meeting held on Tuesday, May 5, 1942:

"That the Council instruct the California Medical Association delegates to the American Medical Association to present to the House of Delegates of the American Medical Association a resolution having for its purpose the outlawing of rebates of all kinds in accordance with long-standing principles of medical ethics."

The Reference Committee approves of the substitute resolution, and commends the Council of the California Medical Association for its action.

I move the adoption of this substitute resolution.

DOCTOR DOYLE: I second the motion.

SPEAKER GOIN: Is there any discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." This section of the report is adopted.

Re: New Resolution.—Shasta-Trinity County Medical Society

DOCTOR WILBUR: In accordance with the provisions of Section 2 of Article III, and Section 9 of Article V of the Constitution of the California Medical Association, the following new resolution is submitted by your Reference Committee No. 3, unanimous consent being requested, Mr. Speaker, to present the same at this time.

SPEAKER GOIN: Does the House give unanimous consent? Do I hear any objections? You may proceed.

DOCTOR WILBUR: Resolution follows:

WHEREAS, At the present time, physicians of Trinity County are members of the Shasta County Medical Society; and

WHEREAS, Trinity County belongs to the Ninth Councilor District of the California Medical Association, while Shasta County is included in the Eighth Councilor District; now be it

***Resolved,* That Trinity County be transferred from the Ninth to the Eighth Councilor District, and that said districts be regrouped accordingly, without any changes to the remaining districts, and that a charter be granted to said two counties under the name of the Shasta-Trinity County Medical Society.**

Unfortunately from your mimeographed sheets was

deleted this paragraph, the Committee's action regarding this change in district allocation.

The purpose this resolution accomplishes is requested by the members of the County Societies involved, and is acceptable to the Councilors of the Eighth and Ninth District. I move the adoption of this resolution.

SPEAKER GOIN: This amendment of the Constitution lay upon the table of the House for one year, so that no action has been taken at this time.

SECRETARY KRESS: Mr. Speaker, the by-laws provide that once in every ten years the Council and the House of Delegates shall make a reapportionment of the Councilor Districts. The House can therefore authorize the proposed change in district allocation.

SPEAKER GOIN: This does not involve amending the Constitution. Dr. Green moves to adopt this resolution. Is there a second?

DOCTOR KIRKPATRICK: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." This section of the report is adopted.

DOCTOR WILBUR: At this point, Mr. Chairman, I should like to thank the other members of the Reference Committee No. 3, and also the young ladies in the office of the Secretary-Editor who have been so helpful to us in preparing this report, and to those members of the House of Delegates who have been kind enough to appear before the Committee and offer help in preparing this report; and I, as Chairman of Reference Committee No. 3, move the adoption of the complete report as amended by the House of Delegates.

DOCTOR MADSEN: I second the motion.

Re: Reconsideration of Resolution on Un-American Activities

DOCTOR MURRAY: I realize that it is quite late, but I am not satisfied with the action that was taken in refusing that resolution on subversive activities. I think, perhaps, a letter from Doctor Pinkham might explain why that resolution. . . .

SPEAKER GOIN: Just a moment, we will have to have a motion to reconsider. Who will make the motion?

DOCTOR KILGORE: Mr. Speaker, I move to sustain the reconsideration of the resolution.

DOCTOR HOPE: I second the motion.

SPEAKER GOIN: The motion is on the reconsideration of that portion of the report dealing with the resolution on un-American activities. All in favor say, "Aye," contrary, "No." The "Aye's" have it, and it, the resolution, is open for further discussion.

DOCTOR MURRAY: I wish to read this letter which I think is self-explanatory.

(LETTER)

To the California Medical Association:

***Attention:* Committee on Public Policy and Legislation:**

The Board of Medical Examiners, individually and collectively, have been approached on several occasions on the question of whether the business and professional code relating to the practice of medicine provides any means for punishment for a charge of subversive activities, and goes on to mention the names of some doctors.

There is no provision in the present code permitting the Board to take any action, and we submit for your consideration the question on whether the California Medical Association will sponsor any amendment along the line mentioned for introduction at the next legislative session.

I quote from a second letter, in regard to the subject in which the same issues are mentioned, and the names of the doctors who have been accused are mentioned. It ends saying,

"We are now engaged in a search of our files to learn the names and addresses of foreign-born aliens, particularly from enemy nations."

We trust that these amendments may be prepared for consideration at the coming legislative session. Thank you very much, Mr. Speaker.

SPEAKER GOIN: Status of this resolution is now the same as it was before you tabled it. There is a motion now pending by the Chairman of the Committee to adopt it. The motion is on the adoption of that section of the report that contains the resolution on un-American activities. Any discussion? Doctor Ayres has the floor.

Discussion:

DOCTOR AYRES: According to the letter from Doctor Pinkham, the suggestion is made that disciplinary action should be taken against a member who is charged with un-American activities. I don't see how it is possible to take any kind of an action if a person is merely charged with some subversive activity. If the individual has been proven to be guilty of it, it would be automatically taken care of by Federal statutes as was previously pointed out. It would hardly seem fair to deprive a person of his right to practice medicine merely because he is accused.

SPEAKER GOIN: Any further discussion? Doctor Kirkpatrick, Shasta Dam.

DOCTOR KIRKPATRICK: Until this item of subversive activities is clarified, I move that this amendment be tabled.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: The motion is now on again tabling the resolution. All in favor say, "Aye," contrary, "No." Those voting "Aye" please rise. The "Aye's" have it. The question now is on the adoption of the report as a whole as amended. Are you ready for the question? Doctor Madsen.

DOCTOR MADSEN: You slid over a communication concerning California Physicians' Service, which was directed to P. K. Gilman, Chairman of the Council of the California Medical Association. I think the report of the letter is excellent, but I feel that the liaison mentioned in the letter should be between our members and the Calfornia Physicians' Service. It seems to me that it is high time that the California Physicians' Service per se be placed in the position where it need not come to Del Monte and defend itself. We all brought California Physicians' Service into existence, and if it is possible in any way to imply that the function of this Liaison Committee should be to carry information to the members of the House of Delegates or the members at large, I should like to see, or ask, that that be recognized. The communication was merely read to the Chairman of the Committee. No action was taken, whatsoever.

SPEAKER GOIN: Well, I don't know of any way that you could stop the members of the California Physicians' Service and the Trustees who are Delegates to this Association to bring up a resolution if they wanted to, Doctor Madsen. They are all privileged to bring in a resolution as they see fit. The question now recurs of the adoption of the report as a whole as amended. Are you ready for the question? All in favor say, "Aye," contrary, "No." Adopted.

I would like to add my thanks to those of Doctor Wilbur to include Doctor Wilbur for the heavy work that this Committee has gone through. (Applause.) They sat for nearly all of two days. At this time, the Speaker would like to confess his own error, assisted by the Executive-Secretary, when, inadvertently having mislaid our list of committees, we announced Doc-

tor Huffman as a member of Doctor O'Neill's Committee No. 1, in place of Doctor McPherson of Santa Cruz County, who really was the member and who served faithfully, and also Doctor Key, and I thank both of them and apologize to Doctor McPherson for not having named him yesterday.

Next order of business is unfinished business. I'll call upon the Chairman of the Council, Doctor Gilman, to discuss the dues for next year and the budget.

Re: State Association Dues for 1943

DOCTOR GILMAN: Mr. Speaker, for the year 1943, the Council recommends the *annual assessment to be $20 per member.* I move the adoption of this recommendation.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? We are about to fix the dues for next year. Are you ready for the question? All in favor say, "Aye," contrary, "No." Carried.

Re: Budget for Year 1943

DOCTOR GILMAN: Mr. Speaker, the Chairman of the Council wishes to announce the *Budget for the Year 1943* at the estimated income and dues to be set at $80,000 instead of the previous estimation of $96,000, owing to the increasing number of members entering into the military service. This is for your information and no particular action is necessary. This income as stated a moment ago if from membership dues, this $80,000. Estimated income from advertising sales $25,000. General subscriptions $600. Reprint sales $500. Annual session $6,000. Miscellaneous, including earned interest, $1,500. A total of $115,600 as against the previous $129,600. There is a total for expenditures of $95,828, leaving an estimated balance of $17,772. I move the adoption of the budget, gentlemen.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? Are you ready for the question? All in favor of the adoption of the budget say, "Aye," contrary, "No." Carried.

Introduction of President William R. Molony

We now come to the more enjoyable part of the agenda and I now have the pleasure and the honor of introducing to you, your new President, Doctor William R. Molony of Los Angeles.

DOCTOR MOLONY: Mr. Speaker, President Rogers, and Members of the House of Delegates: A year ago at Del Monte you honored me by electing me President-elect of the California Medical Association. Needless to say, I was extremely appreciative, and tonight, after a year's service to the California Medical Association as your President-elect, I became your President. On this occasion you will permit me to delve into some past history of a personal nature. My experience with the affairs of the California Medical Association goes back to about 1910. A few years later, I was appointed and served as Chairman of the Reference Committee of the House of Delegates in Coronado. At that time, there was only one Reference Committee. That annual session was held during the administration of Doctor George H. Kress, who was State Association President at that time. Since then, I have taken an active and continued interest in the California Medical Association. For twenty-seven years, beginning with 1913, I was honored and very happy in the privilege of serving the State of California and my colleagues in medicine as a member of the Board of Medical Examiners, for which board I had the pleasure of serving as President some years. For an entire decade, also, it has been my great pleasure and honor to serve as a delegate to the American Medical Association from California. About ten years ago, my colleagues in Los Angeles, my native city honored me by electing me President of the Los Angeles County Medical Association. All these honors and privileges have been dwarfed by the great honor that has come to me tonight, when I became President of the California Medical Association. The only regret arises from the fact that my wife, who has been with me through all my trials and labors for forty-five years, is unable tonight, by reason of ill health, to share with me in this honor tonight. However, I feel that, to be the President of this organization and to look back upon the illustrious line of great men who year after year, have served as your Presidents, one should be proud to follow in their footsteps. May I say to you that I shall do my very best, not in an effort to excel them, because that can't be done, but to emulate their examples and try to promote all the traditions and ideals that will make for betterment of medical conditions in California. I thank you. (Applause.)

Introduction of President-Elect Karl L. Schaupp

SPEAKER GOIN: I shall now ask Doctor Philip Gilman and Doctor Lowell Chandler to escort Doctor Karl L. Schaupp to the rostrum. Delegates, your President-elect, Doctor Karl L. Schaupp of San Francisco. (Applause.)

DOCTOR SCHAUPP: Thank you all for this honor which you have placed upon me. I shall try in the following year as President-elect to gather up the threads that I have lost touch with, in the last two years. I shall try in every way possible to carry out thoroughly and fearlessly the wishes of this supreme body of the California Medical Association, the House of Delegates. Thank you. (Applause.)

Remarks of Speaker Lowell S. Goin and Vice-Speaker E. Vincent Askey

SPEAKER GOIN: The Speaker is now directed to present the Speaker, but since it turns out to be "that man again," I will only say that I thank you very much for the expression of confidence, and will continue to try to do the very best that I can, I am pleased to present to you, now, your Vice-Speaker, Doctor Askey. (Applause.)

DOCTOR ASKEY: Members of the House of Delegates and Friends: I don't think that I need to say anything, except that I appreciate the honor which you conferred on me last year and which you have given me again. I thank you very much. (Applause.)

Remarks of Retiring President Henry S. Rogers

SPEAKER GOIN: The Chair now recognizes a past President of the Association, Doctor Harry Wilson.

DOCTOR WILSON: Mr. Speaker and Members of the House: I seem to have the bad duty of helping usher a man out instead of the joyous one of welcoming a man in. The Reference Committee's Report tonight dealing with the President's activities gave you a very slight intimation of the arduous duties that have fallen on Doctor Rogers' shoulders. I don't think any of you can really appreciate what he has given of himself to the Association. Following past custom, and presenting to Doctor Rogers this certificate, which is the acknowledgement of his services to you and the honor which he has received from you, I know it is your hope with me that, as he glances at it from time to time, he will forget the small disappointments that happened to him through the year, and will, on the contrary, remember the many pleasures he had during his years of service. So, I can only welcome Henry who has been so de-

OFFICIAL BUSINESS

Alameda County Medical Association Resolutions Concerning Professional Membership in California Physicians' Service

The minutes of the House of Delegates of the California Medical Association give several references to a resolution adopted by the Council of the Alameda County Medical Association having to do with resignations of professional members of California Medical Association.*

The matter was also referred to in the C. M. A. Council, as noted in the June issue of CALIFORNIA AND WESTERN MEDICINE. (On page 357, Item 8; and on page 358, Item 4.)

Under date of June 3rd, the following were received from Doctor Gertrude Moore, Secretary of the Alameda County Medical Association:

* * *

(COPY)

ALAMEDA COUNTY MEDICAL ASSOCIATION
Office of the Secretary-Treasurer
353 30th Street
Oakland, California

June 3, 1942.

Captain Philip K. Gilman,
Chairman, Council of California
Medical Association,
San Francisco, California.

Dear Captain Gilman:

Enclosed please find resolutions passed by the Council of the Alameda County Medical Association at a recent meeting.

Sincerely,

(Signed) GERTRUDE MOORE, M. D., *Secretary.*

Encl.

* * *

(COPY)

WHEREAS:

The Council of the Alameda County Medical Association on February 13, 1942, passed a resolution disapproving California Physicians' Service as now constituted and operated and advised the members of the Alameda County Medical Association who were professional members of California Physicians' Service to resign from California Physicians' Service; and

WHEREAS:

The Council of the California Medical Association on May 3, 1942, asked, in the interest of organized medicine that this resolution be rescinded;

THEREFORE, BE IT RESOLVED:

That the Council of the Alameda County Medical Association rescind this resolution of February 13, 1942, relative to California Physicians' Service, effective June 3, 1942; and

BE IT FURTHER RESOLVED:

That this action is taken solely at the request of the Council of the California Medical Association in order to prevent open dissension in the medical profession and does not indicate a change in the opinion of the members of the council of the Alameda County Medical Association relative to the California Physicians' Service.

* * *

The "Bulletin of the Alameda County Medical Association," in a subsequent issue, in addition to the resolution printed above, gave additional comment over the name of Safford A. Jelte, President of the Alameda County Association, as follows:

(COPY)

PRESIDENT'S MESSAGE

"Your Council has unanimously passed the following resolution:

(Resolution as per above)

"In taking the above action your Council has made an effort to preserve harmony between the official medical bodies concerned; it has, at the same time, reiterated its stand with regard to the present constitution and operation of California Physicians' Service. Its opinion is in no sense binding upon any of the members of this Association, who are perfectly free, as they always have been, to serve California Physicians' Service as professional members, or not, as they see fit. In the long run, a medical payment plan will prosper or fail on its own merits. If it is soundly constituted and operated it will succeed; if not, its ultimate demise may be delayed, but not prevented, by the artificial support of medical bodies organized primarily for scientific advancement.

"Your Council hopes that with the passage of the above resolution the controversy over this matter will be ended."

SAFFORD A. JELTE, *President.*

* See Report of Reference Committee No. 2 on page 80.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT**

Letter Received from the Federal War Manpower Commission

Editorial comment on the letter which follows and which was received from Major (now Colonel) Sam F. Seeley appears in this issue.*

Because of its importance, Colonel Seeley's communication is also given place in this column, which hereafter, in general conformity with action taken in Atlantic City, at the A.M.A. session, will hereafter appear under the caption: "California Committee on Participation of the Medical Profession in the War Effort."

(Copy of Telegram Sent to Major Seeley)

WESTERN UNION

June 19, 1942.

Major Sam F. Seeley,
601 Pennsylvania Avenue, N.W.,
Washington, D. C.

To emphasize Mr. McNutt's Atlantic City remarks, we need following information. One, total number of California physicians now in active service in Army. Two, total number of California physicians still needed to meet California's quota at present date. Three, total number

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Henry S. Rogers, M. D., room 1938, 450 Sutter, San Francisco, is a member of the American Medical Association Committee on Medical Preparedness, and is chairman of the Ninth Corps Area Procurement and Assignment Service.

Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86. See also in this issue on following page.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (FEderal 1953).

** Committee on Medical Preparedness department in C. & W. M. will hereafter appear under this caption.

* For editorial comment, see page 1.

serving into the Ancient Order of Past Presidents. (Applause.)

DOCTOR ROGERS: President Molony, President-Elect Schaupp, Mr. Speaker, and Members of the House: Now that I am leaving you, I would just like to have a little heart-to-heart talk. There is something about this House of Delegates that, when you are elected a President-Elect, no matter how calm you seem to be up to that moment then when you come up here it is impossible to find speech to adequately express your feelings. Also that is true—or at least it was in my case—when one is presented to you as your President. Now, that I am leaving you, to become a Past President, I really want to call to your attention to one impression in this State, that I believe detracts from the effectiveness when the Officials of the Society visit your county societies. It also lessens the effect and value of the editorials on subjects published. I refer to the widespread statements that the officers of the Association and the Council are medical politicians. Now, I am not saying anything about myself, but I have served on this Council for better than eighteen years, and in that time I have never worked with a finer or more broad-minded or scholarly group of men than those you have elected to this Council. They serve you self-sacrificingly. Let us pause and analyze the make-up of your present Council. At the present time, you have five general practitioners; four ear, nose and throat specialists; three surgeons; two internists; two pediatricians; one radiologist; one industrial surgeon; two obstetricians. Seven of these Councilors are teachers in the four medical schools we have in California. All of your Councilors are practitioners who live and work among you, and all are highly respected by their confreres. They are here as your officers because you select them, knowing they are good men and men who will work without stint for the progress of medicine. I would like to ask you, who are here tonight, as members of the House of Delegates, to go back to your County Societies and explain to your fellows, that while your Councilors must be keenly alert to political values and trends, such work in your behalf does not make them politicians, in the cheap sense of that term. They are working for you and for medicine, and they are giving a lot of themselves and a lot of their own money while they are promoting the best interests of medicine of which your own are a part. I give you thanks for being President. I did the best I could and that is all any one man can do. I am now returning to the practice of medicine in a little country town and as the years roll by I hope to devote a little more of my time to reading the literature, watching the new drugs, as they come along, and the new treatments. I shall continue to help the officers of the society in any way that I can, to promote the practice of medicine, which profession is, in my estimation, the finest line of life work any man can take up. I thank you all for the opportunity you have given me to serve you. And I want to thank all of the officers of the Association, the Committees, and particularly those who helped with the entertainment last night. As I am leaving you, gentlemen, I again thank you. (Applause.)

SPEAKER GOIN: I don't know whether or not I ought to let you in on this, but the fact is that, in spite of those two obstetricians on the Council that Doctor Rogers mentioned, the Council sometimes has pretty difficult labor for considerable periods of time. The Chair now recognizes Doctor Sieber of Santa Rosa.

* * *

Presentation of Gift to Past President Rogers:

DOCTOR SIEBER: You who come from Los Angeles County and around the Bay Region must get used to having Presidents picked from among our members, but we from Sonoma County see it as a very rare event. We have been very happy during this past year, and have been very proud to have Doctor Rogers of Petaluma as the State President. In spite of the fact that he has been very busy with the State Association work, he has been a most faithful member of our County Society. In fact, we have had great difficulty in doing anything behind his back. Recently, however, we did do a little underhanded business, and at this time I am very happy on behalf of the Sonoma County Medical Society in presenting Doctor Rogers with this little token of appreciation from the Sonoma County Medical Society. (Applause.) (Presents a handsome case of smoking pipes.)

DOCTOR ROGERS: Doctor Sieber, I'm almost speechless. You know, when I was elected as your President-Elect, I went home and Doctor Peoples, my neighbor, dropped in and said, "Henry, are you going to the medical meeting tonight?"

I said, "My God, I'm tired. I just got in from a trip some place today. I don't really think I ought to go, but I think I will go with you."

And when I got up there, I found these boys had decorated the meeting room with flowers and "what have you." It made me very, very happy. This present gift from these boys with whom I have lived and practiced medicine means a whole, whole lot to me. Thanks to the members of the Sonoma Medical Society.

* * *

Committee to Edit Minutes

SPEAKER GOIN: It is customary at this time to entertain a motion to appoint the President, the Association Secretary and the Speaker as a Committee to edit the electrically-transcribed minutes.

DOCTOR RUDDOCK: I so move.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." So ordered.

Vote of Thanks

Before we adjourn, I want to thank the Chairmen and members of the Reference Committees. Those of you who have been on those committees know how much work is involved, how much of your time it takes, and how much it spoils your other enjoyments of the meeting. Someone has to do these chores for the Association, and I am grateful, and I am sure that you are all grateful to all of these men who gave us their time for these other important tasks.

Adjournment

The Chair will now entertain a motion to adjourn.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: The House is adjourned.

House adjourned at 12 midnight, on Wednesday, May 6, 1942.

LOWELL S. GOIN, *Speaker*
GEORGE H. KRESS, *Secretary*

Attest: HENRY S. ROGERS, *President*, 1941-1942
WILLIAM R. MOLONY, *President*, 1942-1943

Life is short, the Art long, opportunity fleeting, experience treacherous, and judgment difficult.—*Hippocrates.*

As to diseases, make a habit of two things—to help, or at least to do no harm.—*Hippocrates.*

If disease and treatment start together, the disease will not win the race.—*Hippocrates.*

More mistakes are made by not looking than by not knowing.—*Jenner.*

state for each of the next six months, under penalty of not meeting our quota and thereby laying ourselves open to compulsion by other interests.

A recapitulation of the commissioning process used by the two recruiting offices in California is in order at this time:

1. Physicians under 37 years of age may be commissioned as first lieutenants; those between 37 and 45, as captains.

2. Physicians between 45 and 55 years of age may apply for commissions, their applications to be acted upon by the Surgeon General and commissions granted in ranks commensurate with their professional attainments and openings existing in the Medical Corps.

3. Physicians under 45 *may* apply for commissions of Major or higher if they are certified by one of the American Boards or if they have other special attainments; these applications must be cleared by the Surgeon General and will be favorably acted upon *only if vacancies exist* where such men may be placed. Physicians in this category should not, however, fail to accept a commission at the rank of Captain if a higher rank is not available. The number of physicians who will obtain initial rank of Major or Lieutenant Colonel is strictly limited. There are already enough medical officers in the Army to qualify for promotion, and newly commissioned physicians will also have the opportunity for promotion available to them.

4. Physicians with prior service in the Army should apply at the same recruiting boards, which will forward their applications to the Surgeon General for action.

For full details, consult the U. S. Army Medical Recruiting Board at 450 Sutter Street, San Francisco, or 1930 Wilshire Boulevard, Los Angeles. Major South in San Francisco and Major Darnell in Los Angeles will be glad to offer you every assistance.

Army needs indicate that within another 12 months every able-bodied physician under 45 years of age will be in uniform. If you come within this group or within the other groups mentioned above, you will promote your own interests by applying now.

Medical Officer Recruiting Board for Southern California

The following item is taken from "The Bulletin of the Los Angeles County Medical Association," issue of June 18, 1942:

The Southern California Medical Officer Recruiting Board has opened permanent quarters at Room 204, Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles. This office is in charge of Major C. A. Darnell.

It is suggested that all doctors desirous of being commissioned in the Army or those who have already applied for commissions a month or six weeks ago and have not heard from their applications, contact Major Darnell at once.

Adjoining these offices are the offices of the Procurement and Assignment Service of Southern California and of Los Angeles County.

The Los Angeles County Committee on Procurement and Assignment Service is composed of the following:

C. G. Toland, M. D., Chairman
Maurice Kahn, M. D.
William H. Kiger, M. D.
Wayland Morrison, M. D.
Fred B. Clarke, M. D., Long Beach
John Dunlop, M. D., Pasadena
William M. Gibbs, M. D., Glendale
John P. Nuttall, M. D., Santa Monica
F. C. Swearingen, M. D., Pomona

Doctor E. M. Pallette has been appointed Vice State Chairman with supervision of the fourteen southern counties.

California Procurement and Assignment Service County Committees for Physicians

County	Chairman	Members
Alameda	Albert M. Meads 251 Moss Ave., Oakland	Warren B. Allen, Oakland Claire Rasor, Oakland
Butte-Glenn	D. H. Moulton 341 Broadway, Chico	J. H. Hepplewhite, Chico Eli A. Kusel, Oroville T. H. Brown, Orland C. E. Plumb, Chico
Contra Costa	L. Abbott Hedges 314 10th St., Richmond	J. Robert Harman, Richmond Selby Marks, Pittsburg
Fresno-Madera	C. D. Collins 2607 Fresno St., Fresno	Frank R. Ruff, Fresno George H. Sciaroni, Fresno G. W. Walker, Fresno R. R. Dearborn, Madera
Humboldt	Joseph S. Woolford 350 E St., Eureka	Benjamin M. Marshall, Eureka John A. Lane, Eureka
Imperial	John L. Parker 120 S. 6th St., Brawley	L. C. House, El Centro C. S. Brooks, El Centro
Inyo-Mono	Harvey W. Crook 106 S. Main, Bishop	Lloyd S. Bambauer, Bishop Selda E. Anthony, Independence
Kern	William H. Moore Haberfelde Bldg., Bakersfield	Lucille B. May, Bakersfield Lloyd Fox, Bakersfield Louis A. Packard, Bakersfield Seymour Strongin, Bakersfield
Kings	Lionel W. Sorenson Corcoran	C. G. Newbecker, Hanford Arthur Zeismer, Hanford
Lassen	George S. Martin Susanville	H. G. Levin, Westwood
Los Angeles	C. G. Toland 1925 Wilshire Blvd., Los Angeles	Wayland A. Morrison, Los Angeles Maurice Kahn, Los Angeles Advisory Board Fred B. Clarke, Long Beach John P. Nuttall, Santa Monica John Dunlop, Pasadena F. C. Swearingen, Pomona William M. Gibbs, Glendale
Marin	Homer E. Marston 1010 B St., San Rafael	George H. Wilcutt, San Rafael M. E. Hazeltine, San Rafael
Mendocino-Lake	Raymond A. Babcock Willits	Paul J. Bowman, Fort Bragg Charles A. Craig, Lakeport Royal Scudder, Fort Bragg Lew K. Van Allen, Ukiah
Merced	Fred O. Lien 557 17th St., Merced	A. S. Parker, Merced B. E. McDowell, Merced
Modoc	Philip W. McKenney Alturas	
Monterey	William H. Bingaman 308 Main St., Salinas	Rudolph A. Kocher, Carmel George A. Starbird, King City
Napa	Dwight H. Murray 1110 1st St., Napa	G. K. Abbott, St. Helena M. M. Booth, St. Helena
Orange	H. G. Huffman 215 S. Main St., Santa Ana	C. Glenn Curtis, Brea D. A. Harwood, Santa Ana Milo K. Tedstrom, Santa Ana John A. Wood, Anaheim L. F. Whittaker, Huntington Beach

of additional California physicians needed for Army by December 31, 1942. Four, average number of California physicians who should enroll each month to permit California to fulfill its quota by December 31, 1942. Kindly send above or related figures.

CALIFORNIA AND WESTERN MEDICINE,
By: GEORGE H. KRESS, *Editor*,
450 Sutter, San Francisco.

(COPY*)

Office for Emergency Management
WAR MANPOWER COMMISSION
Washington, D. C.
Chairman, Paul V. McNutt
Federal Security Administrator
Procurement and Assignment Service for Physicians, Dentists and Veterinarians

June 20, 1942.

Dr. George H. Kress, Editor,
CALIFORNIA AND WESTERN MEDICINE,
San Francisco, California.

Dear Dr. Kress:

In response to your telegram of June 19, the following round figures should be used as a basis for your calling to the attention of the medical profession of California the necessity of their early participation in the war effort. California's quota, in addition to interns and residents, is 2600, to be filled by December 31, 1942. Figures in this office indicate that less than 1000 are now in military service and your quota for the balance of the year is to be not less than 1800.

Dr. Harold A. Fletcher, 490 Post Street, San Francisco, and Dr. Edward C. Pallette, 1930 Wilshire Boulevard, Los Angeles, are responsible as our State Chairmen for Physicians in California, to determine the availability of physicians in that State. I would emphasize that the majority of physicians of military age, i.e., those under 45, must anticipate military service sooner or later except in the proven instances where they cannot be spared from civil life.

In the majority of the instances the deferment of a man under 45 can only be considered temporary and wherever necessary a replacement should be obtained from among those over 45, the women physicians, or those under 45 who have been rejected for military service. It is the opinion of this office that more than one-half of California's quota should be filled within the next sixty days and that a minimum of 1800 must enter the military service without fail. Since the question of dependency has practically been eliminated under Selective Service opinions, the remaining cause for deferment is occupational. In those cases where this office considers a man to be available, we feel justified in challenging deferment on an occupational basis. We do not want to have to resort to such a challenge. We look to the patriotism and enthusiasm of the medical personnel in California to meet this demand on a voluntary basis and have set July 1, 1942 as the date to which we look forward when an appraisal of the situation will be carefully considered by the Directing Board in determining its future policies.

Sincerely yours,
(Signed) SAM F. SEELEY, M. D.,
Executive Officer,
Procurement and Assignment Service.

(COPY)

Office for Emergency Management
WAR MANPOWER COMMISSION
Washington, D. C.
Chairman, Paul V. McNutt
Federal Security Administrator
Procurement and Assignment Service for Physicians, Dentists and Veterinarians

June 25, 1942.

George H. Kress, M. D., Editor,
CALIFORNIA AND WESTERN MEDICINE,
San Francisco, California.

Dear Dr. Kress:

In response to your letter of the 20th, the following comments are offered:

Your figures are correct except for,

Item (4) M. D.'s under age of 45—72,000.

Items (6), (8) and (9) [re: number of California licentiates, etc.], are not known to be correct as far as I can determine. This can be compiled, however, from the list of physicians in military service as of April 30, which has been transmitted to the office of Dr. Fletcher.

My records show that 833 were on active duty from California as of May 1.

Sincerely yours,
(Signed) SAM F. SEELEY, M. D.

California Procurement and Assignment Service

Direct recruiting of medical officers for the Army of the United States is now a reality. Recruiting boards have been established in San Francisco and Los Angeles, and applicants may secure full details, final type physical examinations and Procurement and Assignment clearance in a minimum time. The goal of the recruiting service is to issue commissions to applicants within 48 hours of the time of application; Procurement and Assignment Service is ready to do its share in accomplishing this.

Inauguration of this service means an end to the long waiting periods that many physicians underwent under former procedures. No longer will you have to wait several months to learn whether or not you are acceptable for an Army commission, meanwhile not knowing whether to close your office, turn patients over to other physicians, etc.

The need for Army doctors is greater today than at any time in the past. The Army expansion program has been so accelerated that there is a crying demand for more doctors to enter the service and prepare themselves for active medical work with new troops. Despite rumors of Army doctors doing everything except the practice of medicine, Army doctors are still doctors, albeit in training for a specific type of medical work required by modern streamlined armies. It is important to remember that at least three months of Army training are needed before a physician is able to render proper service as a military physician.

At the A.M.A. meeting at Atlantic City the need for Army doctors was placed squarely before the profession on the basis of a voluntary program which the profession has first chance at carrying out. If the voluntary process fails, pressure will be brought to bear from one of the numerous Government agencies which have been given supreme authority by the Congress. The profession will do well to heed the warning and the need.

California's quota of new Army medical officers for the balance of 1942 is about 1500. This means that an average of 250 doctors a month must be recruited in this

* Major Sam F. Seeley's letter, as received from him, is here printed. It also appears in this issue for editorial comment, with additional paragraphing for convenience in reference.

WHEREAS, The American medical profession has never failed in any previous emergency to meet the needs of the armed forces of our country for medical officers; and

WHEREAS, The Procurement and Assignment Service for Physicians, Dentists and Veterinarians was established by the President of the United States to enable the medical profession to meet all the demands placed on it to provide medical officers for all the governmental services, for industry and for our civilian population; therefore be it

Resolved, By the House of Delegates of the American Medical Association that we tender to Mr. Paul V. McNutt our appreciation of his message and of his coöperation; that we pledge to the President of the United States, to the War Manpower Commission, and to the Procurement and Assignment Service every aid that this organization can possibly render in meeting this objective, and that the Board of Trustees and the War Participation Committee of the American Medical Association be requested to give consideration to all of the means by which these objectives may be attained.

* * *

Report of Reference Committee on Military Preparedness

Dr. John H. O'Shea, Chairman, presented the following report, which was adopted on motion of Dr. O'Shea, seconded by Dr. William R. Brooksher, Arkansas, and carried:

Resolution on Message from Mr. Paul V. McNutt: Your reference committee recommends approval of this resolution, [see above] and that it be referred to the newly created War Participation Committee of the American Medical Association for continued action.

State Chairmen of the California Procurement and Assignment Service

By now, most physicians are aware that the medical division of President Roosevelt's War Manpower Commission has a national medical board of five, of which Dr. Frank Lahey—A.M.A. president in 1941-1942—is chairman; and that for each of the nine Army corps areas and the associated Navy districts there is a corps area chairman—in the ninth corps area, the late Charles A. Dukes, M. D., of Oakland, was succeeded by C.M.A. President, Henry S. Rogers of Petaluma; and further that in each of the seven Pacific States, composing the Ninth Corps Area, there is a State Chairman on Medical Preparedness Committee, the work of which is now being carried on under the "Procurement and Assignment Service." Philip K. Gilman, M. D., of San Francisco, and Chairman of the C.M.A. Council, was in charge of this work in the beginning, but when Captain Gilman went into active service in the U. S. Navy, with headquarters in San Francisco, the mantle was placed on the shoulders of Harold A. Fletcher, M. D., of San Francisco, who gave up his work as Chairman of the San Francisco Society Committee on Medical Preparedness, when he assumed his duties as State Chairman.

More recently, the Medical Preparedness Committees have practically been merged into the Procurement and Assignment Service. Because of the size and diverse interests of California, Dr. Fletcher found it desirable to have an Associate State Chairman, and for this work Edward M. Pallette of Los Angeles, who was Chairman of the Los Angeles County Society Committee. received appointment from Washington, to assume supervision of the work in the fourteen southern counties.

In every county of the State, a County Committee on Procurement and Assignment has been appointed, these being listed in the current issue of CALIFORNIA AND WESTERN MEDICINE.

Since the tasks which have been allocated to the two State Chairmen on Procurement and Assignment—Doctors Harold A. Fletcher and Edward M. Pallette—will necessitate in many instances, interviews of a somewhat personal nature, the Editor has secured photographs of these two, well-known members of the California Medical Association, and the same are appended hereto. with some biographical data. The tasks assumed by Doctors Fletcher and Pallette and their associated County Committeemen, in furtherance of the objectives to which our Country is committed, are serious and heavy. The State and County Committeemen aproach the solution of the problems they are respectively called upon to solve, with deepest appreciation of the interests of all concerned. Whole-hearted coöperation in their endeavors to carry on to Victory, is requested.

Some comments, now, concerning the two State Chairmen on Procurement and Assignment Service.

* * *

Harold A. Fletcher, M. D.
Chairman, California Procurement and Assignment Service

Harold A. Fletcher, M. D., a native of Michigan, was born on December 10, 1888. Preliminary schooling was in Berkeley. College education at University of Nevada and University of California, graduating in 1912. Medical education and internship at Stanford, 1916. Served in the last war, with Base Hospital No. 47, in San Francisco. Overseas for 10 months, in France. Entered practice of medicine in San Francisco after war, specializing in ear, nose and throat. Has been on teaching staff at Stanford since 1919. Now Clinical Professor in Surgery in the department of ear, nose and throat at Stanford. Is a member of the San Francisco County Medical Society; California Medical Association; Fellow of American Medical Association; member of the American Rhino-Oto-Laryngological Society. Member of the American Otological Society, Pacific Coast Oto-ophthalmological Society. Former chairman and vice-chairman of section of Ear, Nose and Throat Section of California Medical Association. President of San Francisco County Medical Society, in 1941. President of the San Francisco Chapter of the League for the Hard of Hearing.

County	Chairman	Members
Placer-Nevada-Sierra		
	Robert A. Peers Colfax	William M. Miller, Auburn Oscar F. Lang, Grass Valley
Plumas		
	W. C. Batson Greenville	W. B. McKnight, Portola B. S. Holm, Quincy
Riverside		
	William W. Roblee 3616 Main St., Riverside	Bon O. Adams, Riverside Ralph Smith, Riverside
Sacramento		
	William J. Van Den Berg 1127 11th St., Sacramento	Orrin S. Cook, Sacramento John L. Fanning, Sacramento Nathan G. Hale, Sacramento Elbert T. Rulison, Sacramento
San Benito		
	Roswell L. Hull 446 San Benito St., Hollister	Lloyd E. Smith, Hollister John J. Haruff, Hollister
San Bernardino		
	Emmett L. Tisinger 575 5th St., San Bernardino	Carlos G. Hilliard, Redlands E. H. Risley, Loma Linda P. M. Lawler, Victorville Francis Crowley, Patton E. L. Weber, Upland
San Diego		
	Bryant Simpson Medico-Dental Bldg., San Diego	L. H. Redelings, San Diego W. W. Crawford, San Diego F. J. Ratty, San Diego R. O. Logsdon, San Diego W. O. Weiskotten (Ex Officio) San Diego
San Francisco		
	John M. Moore, Vice-Chairman 2180 Washington St.	Harold A. Fletcher, Chairman L. R. Chandler, San Francisco Alexander F. Fraser, San Francisco Albert E. Larsen, San Francisco
San Joaquin		
	Hudson Smythe Medico-Dental Bldg., Stockton	H. S. Chapman, Stockton Dewey Powell, Stockton R. L. Owens, Lodi J. Frank Doughty, Tracy
San Luis Obispo		
	Ira B. Bartle 722 Marsh St., San Luis Obispo	Harold L. Graham, Arroyo Grande John R. Ransom, San Luis Obispo Frederick F. Ragsdale, Paso Robles
San Mateo		
	Ernest W. Cleary 146 Chapin Lane, Burlingame	Edwin Bartlett, So. San Francisco William Knorp, San Mateo Carl Benninghoven, San Mateo Robert Monteith, Redwood City Thomas Farthing, San Mateo
Santa Barbara		
	Hugh F. Freidell 1515 State St., Santa Barbara	Albert M. Beekler, Santa Maria Lawrence F. Eder, Santa Barbara Harry E. Henderson, Santa Barbara Harry L. Schurmeier, Santa Barbara Irving Wills, Santa Barbara Alfred B. Wilcox, Santa Barbara
Santa Clara		
	A. A. Shufelt 241 E. Santa Clara St., San Jose	Leon P. Fox, San Jose J. Irving Beattie, San Jose D. R. Threlfall, San Jose Robert Powers, Palo Alto J. A. Cary, Morgan Hill Burt L. Davis, Jr., Palo Alto J. C. Cuneo, San Jose George A. Gray, San Jose James P. Lovely, San Jose Max E. Pickworth, San Jose William H. Geisler, San Jose
Santa Cruz		
	Alfred L. Phillips 84 Walnut Ave., Santa Cruz	F. E. Blaisdell, Watsonville D. S. Woodard, Watsonville N. R. Sullivan, Santa Cruz Frederick R. Shenk, Santa Cruz
Shasta		
	John E. Kirkpatrick Shasta Dam	Clarence C. Gerrard, Redding Benjamin F. Saylor, Redding Julius M. Kehoe (Ex Officio), Redding
Siskiyou		
	V. W. Hart Yreka	C. C. Dickenson, McCloud Russell J. Merret, Dunsmuir (W. L. Kleaver, D.D.S.—Dental Member)
Solano		
	Ream S. Leachman 727 Sonoma St., Vallejo	John W. Green, Vallejo F. Burton Jones, Vallejo
Sonoma		
	R. L. Zieber 834 4th St., Santa Rosa	E. D. Barnett, Santa Rosa Cuthbert M. Fleissner, Santa Rosa S. Z. Peoples, Petaluma Chester Marsh, Sebastopol Frank E. Sohler, Healdsburg Carroll B. Andrews, Sonoma
Stanislaus		
	Fred R. DeLappe 1901 Downey Ave., Modesto	John A. Cooper, Modesto Hoyt R. Gant, Modesto
Tehama		
	Frank L. Doane 737 Washington, Red Bluff	Homer H. Beck, Corning Arthur H. Meuser, Corning
Tulare		
	A. W. Preston 222 West Willow, Visalia	James C. McClure, Lindsay R. W. Rosson, Tulare C. S. Ambrose, Visalia
Tuolumne		
	Homer D. Rose Wenzel Bldg., Sonora	H. W. Schwing, Sonora
Ventura		
	Grundy C. Coffey 23 S. California St., Ventura	Fred A. Shore, Ventura Jabez A. Mahan, Oxnard William Felberbaum, Santa Paula Harold B. Osborn, Fillmore Franklin H. Garrett, Camarillo
Yolo		
	William J. Blevins Porter Bldg., Woodland	John Homer Woolsey, Woodland Leo A. Cronan, Davis
Yuba-Sutter-Colusa		
	Irving D. Johnson 309 C St., Marysville	Neal M. Loomis, Yuba City Grantville S. Delamere, Marysville Charles B. Kimmel, Marysville

Procurement of Physicians for the Armed Forces

The first editorial in the *Journal of the American Medical Association*, on page 712 of the issue of June 27th, was a discussion having the above caption. The following excerpt is taken therefrom:

"Elsewhere in this issue appears a statement by Mr. Paul V. McNutt, chairman of the War Manpower Commission, under which the Procurement and Assignment Service for Physicians, Dentists and Veterinarians functions, relative to the urgent need for physicians for the armed forces at this time. Mr. McNutt recognizes the indispensable character of the physician for both military and civilian needs. He makes clear that eight states—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—must supply most of the physicians needed for the armed forces at this time. Some of the states have already supplied so many physicians in proportion to their total medical population that recruitment in those states is to be discontinued now or in the near future."

A.M.A. Resolutions Re: Hon. Paul V. McNutt*

Dr. Charles H. Henninger, Pennsylvania, presented the following resolution, which was referred to the Reference Committee on Military Preparedness:

WHEREAS, There has come to this House of Delegates a message directly from the chief of the War Manpower Commission, Mr. Paul V. McNutt, indicating the needs of the nation in this great emergency for the services of the physicians of our country; and

* From minutes of proceedings of A.M.A. House of Delegates, Atlantic City session, June 9, 1942 and June 11, 1942. (See J.A.M.A., June 27, 1942, on pages 725 and 730.)

Former chairman of Committee on Medical Preparedness of San Francisco County, chairman of California Medical Association Committee on Medical Preparedness. California State chairman of Procurement and Assignment Service for Physicians.

* * *

Edward M. Pallette, M. D.
Associate Chairman, California Committee on Procurement and Assignment

Almost a native son of California, Doctor Pallette came to Los Angeles with his parents as a boy in 1889 and that city has been his home ever since.

Did his pre-medical work at Northwestern University in Evanston, graduating in 1894. Did graduate work in Biology and received his Master degree in '95. Received the degree of Doctor of Medicine from the College of Medicine, University of Southern California in 1898. Was for a short time in the Los Angeles City Health Department. In 1901-02 did graduate medical work in New York, London, Berlin and Vienna. Has practiced in Los Angeles since, giving special attention to gynecology. For a number of years was Professor of Physiology in the College of Dentistry, U.S.C., and taught histology and embryology in the College of Medicine.

Was President of the Los Angeles County Board of Education in 1898-99. Member of the Los Angeles City Board of Health, 1904-06, and of the California State Board of Health (Vice-President), 1932-40. Ex-President of the Los Angeles Obstetrical and Gynecological Society. President of the Los Angeles County Medical Association, 1918, and of the California State Medical Association, 1927. Was a Founder-Director, and is still Director-Treasurer of the Hospital Service of Southern California. Member of the Board of Trustees of the Medical Society of the State of California. Fellow of the American College of Surgeons. Has been a Delegate to the A.M.A. for the past ten years. Elected Trustee of the A.M.A. in 1942.* Chairman of Executive Committee of Medical Society of State of California. Served as Captain, Medical Corps, United States Army, World War I, at Letterman Hospital, San Francisco and at Camp Crane, Allentown, Pennsylvania.

Re: Medical Reserve Officers

A special drive for the recruitment of physicians who formerly held Army reserve commissions and either allowed them to lapse or resigned them rather than accept active duty has been started by Army officials. A list of those physicians who have resigned their commissions in the last two years is being prepared for this purpose, the list including close to 400 physicians for one section of California alone. The Army hopes, by using this list for medical recruiting work, to fill a large part of the California quota of some 1600 new medical officers by the end of 1942. Former holders of reserve commissions may obtain full information on the issuance of new commissions from the two Army Recruiting Boards in California.

C.M.A. MEMBERS IN MILITARY SERVICE**

Sacramento Society for Medical Improvement

Members of the Sacramento Society for Medical Improvement on Active Duty with the Army and Navy.

(Report, as of June 16, 1942. Total Number, 15.)

Name	*Rank* (if known)	*Service* (if known)
Adams, Elliott L.	1st Lieut.	Army
Babcock, Daniel W.	1st Lieut.	Army
Chambers, Jack V.	Lieut.	Army
Christian, Samuel	1st. Lieut.	Army
Day, Proctor W.	Lt. Comdr.	Navy
Dillon, Joseph, Jr.	Lieut.	Navy
Fuiks, Dellivan	Major	Army
Harding, William F.	1st Lieut.	Army
Isoard, Max C.	Major	Army
Kanner, Harry M.	1st Lieut.	Army
Phillips, Albert D.	Major	Army
Sarkisian, Milton V.	1st Lieut.	Army
Specker, Lewis	Captain	Army
Teall, Ralph C.	Captain	Army
Thomas, Bert S.	Lt. Col.	Army

San Diego County Medical Society

Members of the San Diego County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 9, 1942. Total Number, 42.)

Name	*Rank* (if known)	*Service* (if known)
Banks, G. F.	Captain	Army
Baxter, C. P.	Lt. Col.	Army
Bernardini, C. V.	Major	Army
Callaway, J. A.	Captain	Army
Chapman, H. J.	Lt. Comdr.	Navy
Churchill, A. G.	Lt. Comdr.	Navy
Colby, E. G.	Lt. Col.	Army
Cooper, A. J.	Major	Army
Egan, A. R.	Lieut.	Army
Eneboe, J. B.	Lieut.	Navy
Fetter, E. M.	Lieut.	Navy
Hanna, C. M.	Lieut.	Army
Harbaugh, O. S.	Major	Army
Hartsough, C. W.	Lt. Jr. Grade	Navy
Holder, H. G.	Major	Army
Hollander, F. G.	Lieut.	Army
Housvicka, O. A.	Lieut.	Army
Jetton, J. A.	Captain	Army
Laird, George	Lieut.	Navy

** County Society Secretaries are requested to submit the lists for their respective counties.

Lane, C. W.—Lt. Comdr.....Navy
Lester, David—Lieut.....Navy
Lindsay, C. V.—Captain.....Army
Lounsberry, R. C.—Comdr.....Navy
Lucic, Hugo—Lt. Comdr.....Navy
Macpherson, F. L.—Lt. Comdr.....Navy
Macpherson, J. D.—Lieut.....Navy
Matson, J. R.—Lieut.....Army
Minna, J. B.—Major.....Army
Morris, G. W.—Captain.....Army
O'Hara, F. P.—Lt. Comdr.....Navy
Olds, John W.—Lt. Jr. Grade.....Navy
Paull, Ross—Major.....Army
Palevsky, S. N.—Lieut.....Army
Present, A. J.—Lieut.....Army
Robinson, F. H.—Captain.....Army
Ryan, W. J.—Lt. Comdr.....Navy
Seiler, W. E.—Lieut.....Army
Svoboda, F. C.—Major.....Army
Wedgewood, P. E.—Lt. Jr. Grade.....Navy
Werden, D. H.—Lt. Comdr.....Navy
Young, E. L.—Captain.....Army
Zukovich, G. E.—Captain.....Army

Santa Clara County Medical Society

Members of the Santa Clara County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 11, 1942. Total Number, 34.)

Name	*Rank* (if known)	*Service* (if known)
Anderson, Frank R.—Lt. Comdr.		Navy
Arminini, George B.—Captain		Army
Campisi, Dominic A.—Captain		Army
Carlson, Carl Oscar—Lieut.		Army
Chesbro, Wayne P.—Lieut.		Navy
Cook, Paul Enos—Lt. Comdr.		Navy
Cragin, Robert B.—Major		Army
Cressman, Ralph D.—Captain		Army
Francis, Kenneth V.—Captain		Army
Gerstle, Mark F., Jr.—Lt. Comdr.		Navy
Haley, Philip S.—Lt. Comdr.		Navy
Hockenbeamer, Ernest P.—Lieut.		Navy
Ishikawa, Tokio—Lieut.		Army
Jenkins, Herbert T.—Lieut.		Army
Jorgensen, Melford B.—Lieut.		Army
Josephson, J. Bernard—Lt. Comdr.		Navy
Lane, Henry F.—Lieut.		Navy
Lawry, Edwin V.—Lieut.		Navy
Lee, Russell V.—Major		Army
Liston, Edward—Captain		Army
Lyon, Thomas P.—Captain		Army
Lytle, Howard W.—Lieut.		Navy
Magoon, Leslie B.—Lieut.		Navy
Maher, Edward J.—Captain		Army
Mitchell, Sidney P.—Lieut.		Navy
Moore, Ferrall H.—Lieut.		Navy
Norberg, Raymond W.—Captain		Army
Pickworth, Max E.—Captain		Army
Pritchard, Jacob L.—Lt. Col.		Army
Rogozen, Alexander—British Civilian Service		
Rouff, Elliot A.—Lieut.		Navy
Wood, Denniston, Jr.—Lieut.		Navy
Wood, George A.—Major		Army
Wright, R. Wesley—Captain		Army

Sonoma County Medical Society

Members of the Sonoma County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 6, 1942. Total Number, 8.)

Name	*Rank* (if known)	*Service* (if known)
Brink, Holden E.—Lt. Sr. Grade		Navy
Clary, Raimond F.—Lieut.		Army
Congdon, Gordon H.—Lieut.		Army
Harr, Ralph V.—Lt. Comdr.		Navy
Hines, Leonard W.—Captain		Army
Koerper, Victor E.—Lieut.		Army
Meyer, Emerson L.—Lieut.		Army
Quarry, Paul T.—Lieut.		Navy

Tulare County Medical Society

Members of the Tulare County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 6, 1942. Total Number, 7.)

Name	*Rank* (if known)	*Service* (if known)
Blasdel, E. K.—Captain		Army
De Busk, Fred—Major		Army
Falk, Harry—Major		Army
Johnson, Cyril—1st Lieut.		Army
McKinnon, D. J.		
Powell, F. G.—1st Lieut.		Army
Zumwalt, Elmo—Major		Army

Yolo County Medical Society

Members of the Yolo County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 5, 1942. Total Number, 3.)

Name	*Rank* (if known)	*Service* (if known)
Gray, Earl—Major		Army
Potter, Henry—1st Lieut.		Army
Robbins, Wilfred—1st Lieut.		Army

Military Clippings—Some news items of a military nature from the daily press follow:

Medics Warned They Must Meet War Emergency

America's physicians were told directly and bluntly yesterday that they must organize immediately to take over the emergency military and civilian medical needs of the nation—or else.

The "or else" phrase was laid down bluntly by Paul V. McNutt, Federal Security Administrator, in a brief and pointed address at Traymore Hotel before the House of Delegates of the American Medical Association at its opening meeting here.

Between now and Jan. 1, 1943, more than 3000 physicians will be needed every month to meet the growing needs of the Army and the Navy, he declared, and at present 5000 must be taken into service before July 1.

Raps 'Lack of Interest'

"There is an apparent lack of interest on the part of your profession to volunteer," he declared, because of reluctance to give up private income for Army pay. "That lack of interest is, in a large measure, based upon the failure to drive home to the average physician the magnitude of the need."

McNutt also declared that medical practice as it has been carried on before the war will be altered drastically—the first statement made by a government official on the much-disputed question of government regulated medical care.

He declared that in "boom defense towns" adequate medical care is vital to keep production lines moving and physicians will have a ready income now. However, the administrator declared, "their economy will certainly sag

after the war and there is need for government assistance to provide clinical equipment—facilities for medical care and otherwise to help in bearing the capital costs of servicing these communities"—after the war.

'Hard' Facts

McNutt added that he was not talking politics or social theory but "plain hard facts" of adjustment during this war and he told the physicians "it will have to be done on your basis, or another."

* * *

Dr. Fred W. Rankin of Lexington, Ky., new president of the Association, declared later that medicine would meet this challenge. "War is now our principal business," he told the first general meeting of the Association. "Our profession is the trustee of the nation's health and as such its obligations are to furnish adequate medical care to the armed forces while at the same time maintaining faithful service to the civilian population and productive war industry installations."

During the war, he added, the medical profession will guard, maintain and even increase public health programs as the need becomes apparent. Dr. Rankin declared that the quality of medical care would not be impaired by the number of physicians being taken into the armed service.

He expressed this belief that in the present emergency physicians would work harder and longer and study harder than they ever did before on the problems of treatment of wounds and diseases.

* * *

In his address last night as retiring president of the Association, Dr. Frank H. Lahey of Boston, declared that the present war will impose demands "which will tax the fortitude and complete resources of this country."

Never before in history have people been called upon for the sacrifices which will have to be made between now and the time the war is won. "As we look back over the past year and realize the alterations in our point of view I prophesy that the changes a year from now will make those of the past appear small in comparison," the Boston physician declared.

Profession to Be Drained

Pointing out that with a possible army of 7,000,000 to 10,000,000 men in uniform by a year from now there will be need for 50,000 to 65,000 physicians, he declared that "the sustaining of home care and institutions, the maintenance of medical attention for those employed in industry and the possibility of medical dislocation" present a challenge to the medical profession "not only in manpower but even more importantly in terms of the intelligence and efficiency with the situation is met."

Dr. Lahey agreed with McNutt in declaring that "although we have accomplished a great deal in altering the psychologic reaction of medicine to the urgency and magnitude of the situation, I feel certain that there are many individuals in medicine who have as yet not realistically appraised the need and the acuteness of the situation." . . . —Atlantic City *Press*, June 10.

* * *

Medical Profession Will Prove Mettle in War, A.M.A. Told*

Dr. Frank H. Lahey, of Boston, retiring president of the American Medical Association, declared yesterday that the present war may reverse present criticism of the medical profession.

The Boston physician, speaking at the A. M. A. conclave in Convention Hall, indirectly struck out at Thurman Arnold and other U. S. government officers who a year ago prosecuted the association for violation of the Sherman anti-trust law and obtained a verdict of guilty on grounds that it was a monopoly acting in restraint of trade. The case has since been appealed but no action on this appeal has yet been taken.

Forget Controversy, He Says

Dr. Lahey asked members of the association to forget this controversy because "the United States government has placed its complete trust in medicine in one of the greatest danger periods it has ever faced." Today's obligation, he added, is to first take care of the men and women who may be wounded abroad and at home.

"The critics of medicine who have accused us of decadence are eyeing this important undertaking in this dangerous period with very great interest. Its successful accomplishment will do more to give medicine an authoritative voice in post-war developments relative to possible changes in medicine than any other thing which medicine can do." He added that the war work of physicians may "make supporters out of one's critics."

5000 Join Colors in 6 Months

Dr. Fred W. Rankin, the incoming president of the Association, declared that physicians were in step immediately after war was declared by Congress and during the past six months more than 5000 physicians and surgeons have joined the Army, Navy and Marine Corps.

Speaking before the opening meeting of the House of Delegates of the Association, the ruling body of American medicine, he declared that "we do share a responsibility for the fact that a sufficient number of physicians of proper age and capacity to care for the rapidly increasing needs of an expanding army has not been forthcoming."

Dr. Rankin said "this is a war of survival" and all other considerations must be forgotten. "We must understand that we fight with unscrupulous brutal enemies in a conflict whose technique by reason of motorized and mechanized equipment of warfare is not only an entirely new technique but one of savagery employed against both armed forces and civilian populations."

Retired Men Must Help

For this reason, he added, physicians who have retired must return to practice to fill the shoes of younger men being taken into service with the armed forces.

This movement is already under way, Dr. Rankin declared, with hundreds of retired physicians volunteering to take the places of men called into service. These men and women who are disqualified for military service because of age or physical deficiencies are doing remarkable service not only in private practice but also in incidental military duty when called on, he added.

Ten thousand physicians are attending the convention, which will continue through Friday.

Big Lack of Physicians

Dr. Rankin said there was still a tremendous lack of physicians to fill the blank files of the Army Medical Corps. He estimated at least 15,000 and perhaps 20,000 physicians would be needed before Jan. 1 to provide medical service for the Army now being recruited.

He added that many physicians have failed to register with the Procurement and Assignment Service organized by the government in coöperation with the American Medical Association. Every physician, he declared, should be registered with the service in the same way that he registers for the draft. . . . —Atlantic City *Press*, June 9.

* * *

All Physicians Under 45 Face Military Service

Twenty-seven dentists, the entire graduating class of the physicians and surgeons school of dentistry at San Francisco, will be commissioned first lieutenants in the United States Army Medical Corps at exercises Monday morning, according to the Associated Press.

Major F. Floyd South, commanding officer of the headquarters for medical recruiting in northern California, said the war department has decreed that all physicians and surgeons below the age of 45 and all dentists below 37, are potentially available for military service. After commissioning, they will be assigned to duty within a short time.—Sacramento *Union*, May 31.

* * *

Doctors Are Told They Must Take Over War Needs

Atlantic City, N. J., June 10.—(AP).—America's physicians were told directly and bluntly yesterday they must organize immediately to take over the emergency military and civilian medical needs of the nation—or else.

The "or else" phrase was laid down bluntly by Paul V. McNutt, federal security administrator, in a brief and pointed address before the House of Delegates of the American Medical Association at its opening meeting here.

Need 3000 Physicians a Month

Between now and January 1, 1943, more than 3000 physicians will be needed every month to meet the growing need of the army and the navy, he declared, and at present 5000 must be taken into service before July 1st.

"There is an apparent lack of interest on the part of your profession to volunteer," he declared, "because of reluctance to give up private income for army pay. That lack of interest is, in a large measure, based upon the failure to drive home to the average physician the magnitude of the need."

Will Alter Practice

McNutt also declared medical practice as it has been carried on before the war will be altered drastically—the first statement made by a government official on the much disputed question of government regulated medical care.

* By Stephen J. McDonough, Associated Press Staff Writer.

He declared that in "boom defense towns" adequate medical care is vital to keep production lines moving and physicians will have a ready income now. However, the administrator declared, "their economy will certainly sag after the war and there is need for government assistance to provide clinical equipment—facilities for medical care and otherwise to help in bearing the capital costs of servicing these communities" after the war.

McNutt added he was not talking politics or social theory but "plain hard facts" of adjustment during this war and he told the physicians "it will have to be done on your basis, or another."

Will Meet Challenge

Dr. Fred W. Rankin of Lexington, Ky., new president of the Association, declared later that medicine will meet this challenge. "War is now our principal business," he told the first general meeting of the Association.

During the war, he added, the medical profession will guard, maintain and even increase public health programs as the need becomes apparent. Doctor Rankin declared the quality of medical care will not be impaired by the number of physicians being taken into the armed service. —Sacramento *Bee*, June 10.

* * *

Doctor Predicts Civilian Medical Care Will Be Cut

Army's Need For Physicians Is Likely to Cause Rationing

Boston, May 27.—(AP).—Dr. Frank H. Lahey, president of the American Medical Association, said last night the nation's civilian population must expect rationing of medical care because of the number of doctors needed in the armed services.

Urged to Enlist

Declaring virtually all physically fit doctors under the age of 45 are wanted in the services, and urging they enlist at once, Dr. Lahey told the Massachusetts Medical Society:

"As the situation becomes more acute and the endeavor more prolonged, there will be changes and modifications as to medical care, and the civilian population must without doubt adjust its lives as satisfactorily to these rationings as to the more tangible ones such as things to eat, wear and ride in."

Dr. Morris Fishbein, editor of the American Medical Association Journal, also advocated physically fit doctors under 45 to enlist, if their work could be taken over by others, because, he said, "You will be called anyway."

45,000 Doctors Needed

He said the army alone will require 45,000 doctors by the end of 1943.

Dr. John F. Fulton, Yale physiologist and aviation medicine authority, told the society's 161st meeting that 20,000 flight surgeons and aviation medical examiners will be required within a year by the nation's expanding army and navy air forces.—Sacramento *Union*, May 31.

* * *

Service Men Getting Best Possible Medical Care, Civic Clubs Informed

America's Army and Navy are the healthiest fighting forces in the world, get the best medical care from physicians farther advanced than any others, Dr. Perrin H. Long, head of the Department of Preventive Medicine at Johns-Hopkins University, declared yesterday. . . .

Dr. Long, in praising the health of the armed forces and medical technique, spoke from experience. He was one of the physicians who was flown to Pearl Harbor soon after the attack there, and in addition he drove 16,000 miles visiting military camps for the purpose of checking on health and medicine, as a representative of the Surgeons General of the forces.

Soldiers and sailors have escaped serious epidemics that civilians have suffered from, including influenza, scarlet fever and measels. Death rates are low and declining. It was notable, he said, that health was good in Army camps which had been hastily prepared and might have been expected to have unhealthful situations. In the numerous hospitals he visited at Army and Navy camps, he said, deaths were due to automobile accidents and similar accidents, almost none to infections.

Dr. Long told of the modern treatment of wounds, with "sulfa" drugs in Pearl Harbor and the amazing results. Soldiers and sailors who had to wait hours for operations were given temporary treatment with "sulfamiracles," the doctors' nickname for these new discoveries, and it prevented wounds from getting more serious.

He and an associate studied several hundred cases in Pearl Harbor and several weeks later checked them again when they were landed on the Pacific Coast. The remarkable recoveries checked with the first inquiries.

As a result of his investigations, and also from studies with research bodies set up by the Government, Dr. Long said that the American people can be assured that the fighting men are getting the best treatment medicine provides.

Dr. Long referred briefly to venereal diseases. As a matter of fact, he said, this is a civilian problem, not strictly an Army or Navy one. Modern treatment in these cases brings swift cures, but the causes of the disease are in the civilian communities and should be controlled by the civilians, Dr. Long declared. He said that he was certain the Army and Navy would gladly coöperate with any community that wanted to solve the problem, but emphasized that he was "quoting myself."

Despite the serious topic, Dr. Long managed to inject humor into his talk. Very amusing was his description of his plight when he was called upon to leave for Pearl Harbor on shortest notice. It was a secret mission and he had permission only to phone his wife that he would be away for an indefinite period, and goodbye.—Atlantic City *Evening Union*, June 10.

* * *

Army Shows Medical Corps Equipment

Atlantic City, N. J., June 10.—(AP).—The Army Medical Corps exhibited for the first time today its new equipment to save the lives of thousands of soldiers during the present war.

Foreseeing the need of rapid transportation to keep up with fast-moving mechanized forces, the Army has developed field hospital units which can be set up and torn down faster than the circus moves in and out of town. One of the chief components of this quick-service unit is a new type ambulance capable of carrying a maximum of 21 men in comfort at speeds up to 50 miles per hour.

Other equipment demonstrated to physicians at the ninety-third annual meeting of the American Medical Association included a complete snow set, including everything from skis and snowshoes to emergency first aid supplies which one soldier can carry on his back.

Army medical officers said that within a short time sulfanilamide or sulfathiazole powders may become a standard part of the equipment of every soldier so that when hit he can immediately treat a wound.

The Army's panzer medical units are going to require increasing quantities of blood plasma in the war effort, Dr. Earl S. Taylor of the American Red Cross told the Association and as many as 2,000,000 Americans may be asked to give their blood.—San Francisco *Chronicle*, June 11.

* * *

Physically Unfit to Be Rehabilitated

The greatest medical, dental and surgical rehabilitation program in the history of the country will be in full swing by summer.

That this progressive nation had to be forced into such a campaign by the necessity of war is an indictment of our good sense. As belated as it is, however, this campaign is of vast importance to the welfare of humanity.

About 200,000 men otherwise fitted for army duty require extensive dental repair work. They are to get it at the expense of the army and the selective service system.

They may go either to their private dentist or to a dentist selected from an approved list. In such a case the bill will be paid by the selective service system. Or the man can go into the army and have the dental work done by army dentists.

A similar rehabilitation procedure will apply to registrants who need surgical or medical repair that does not require too much time.

The program has been started in Maryland and Virginia as testing grounds. When sufficient experience has been gained it will be extended to the rest of the country on the largest possible scale commensurate with the equipment and dental and medical personnel available.

That 200,000 men of military age are unfit because of need of dental or surgical attention is the result of lack of proper public clinics. The war has focused attention on this and other glaring defects in our social system. The post-war period will be marked by demand for correction of such weak spots in our civilization.

Socialized medicine may not be the answer, but at least government is to indicate a greater interest in the health of the people.—San Bernardino *Sun*, May 24.

* * *

Greater Need for Doctors in War Work Bared

Civilians Urged to Reduce Demands on Physicians

Chicago, June 24.—(INS).—Preventable illness and unreasonable demands on the time of physicians must be reduced to a minimum because of the urgent need for

physicians for the armed forces, Paul V. McNutt, chairman of the War Manpower Commission, warned tonight.

In a statement published in the current issue of the Journal of the American Medical Association, McNutt pointed out that the recruitment of physicians has lagged behind expected quotas. He warned that unless voluntary recruitment progresses more rapidly, some more vigorous form of selective service must be resorted to.

City Areas Lag

"The case is urgent," McNutt stated.

"In fairness to the recruitment record of many of our States," he wrote, "it seems in order at this time to give the (medical) profession some further idea of how its problem is distributed. The failure of a sufficient number of physicians to volunteer for military service is not spread thinly over the whole country. There is an acute lag in populous States. Other States have supplied nearly all they should supply.

"We need more than 20,000 additional physicians by the end of this year. But eight States—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—should account for nearly 16,000 of that shortage."

Bottlenecks Cited

The Journal in the same issue reviewed the situation as pictured by McNutt and commented, in part:

"The medical profession cannot be accused of failure to play its part in every way in relationship to the war effort. Every one who is participating in the recruitment of physicians recognizes that there have been bottlenecks to be cleared away as the effort has progressed."—San Francisco *Examiner*, June 25.

* * *

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Committee on Public Health Education
Basic Science Initiative: On November Ballot

The Basic Science Act has passed its first test; it has qualified for the November election with the filing of 230,179 valid signatures, or some 18,000 more than the legal requirement of 212,117.

This act will be Proposition Number 3 on the November election schedule.

So far, so good. We have accomplished what we set out to do in qualifying this measure. Now we have the more strenuous and all-important job of passing it. We need a majority of the votes cast in November to put this measure on the statute books. More than half of all those who vote in November must register a "Yes" vote on Proposition Number 3 if we are to have the higher standards of practice envisaged by the Basic Science Act.

Boiled down to practicalities, this means that every member of the profession must get out and work for the passage of the Basic Science Act. This must be a campaign where every individual gets behind the bill and pushes. There are numerous ways in which this can be done, and at the proper time these ways will be suggested to you. There will be ample management of the campaign, but management will fall down without a supporting organization. The part of every physician will be in the organization on the firing line.

Right now there is no request to be made of you except that you keep in mind the benefits to be gained by the passage of the Basic Science Act and make sure that everyone with whom you talk does not leave you with any antagonism to the bill. Wage a protective conversational campaign at this time; do not start out on a crusade to gather votes, but rather keep your ears open for adverse comments which you can correct immediately. When the time comes, you will be asked to solicit favorable votes. At that time your efforts will be urgently needed and asked for.

With your help, California may gain the benefits of higher standards of practice that already obtain in 16 states and the District of Columbia where Basic Science Acts are now in effect.

* * *

Medical Bill Qualifies for November Ballot

Examiner Bureau, Sacramento, June 24.—Submission of petitions bearing 165,376 signatures from Los Angeles County today qualified a basic science initiative measure for the November general election ballot.

The proposed act, sponsored by both the California Medical and Dental Associations, would establish a new board of examiners in basic sciences which would conduct examinations in these fields for applicants for licenses in the various healing-arts. Candidates successfully passing board examinations would then apply to the board of medical examiners or other licensing agencies for permits to practice.

Deputy Secretary of State Charles J. Hagerty said the Los Angeles filings brought to 230,179 the number of valid signatures filed in behalf of the measure, against 212,117 necessary to qualify it.

With the deadline for initiative and referendum measures tomorrow midnight, only two other issues have qualified thus far for a place on the ballot. One is the referendum on the legislative "hot cargo" bill and the second is the new building and loan act qualified for the ballot during the legislature's battle over the Pacific States Savings and Loan Company.—San Francisco *News*, June 25.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Long Beach Home Defense Show

The Council of Civilian Defense of Long Beach, California, early this spring recognized the need of a well informed civilian population for the efficient functioning of any civilian defense program.

In spite of the fact that much publicity had been given to the individual's responsibility in the event of a war emergency; in spite of the numerous educational programs presented by the various agencies in the defense set-up; the people of that city, just like the people of all other cities of this country, failed to recognize generally that home defense is really a matter of individual responsibility and knowledge of what to do.

The Long Beach Council of Civilian Defense to bring this knowledge dramatically to the mass of the people, presented a Mammoth Home Defense show at the Municipal Auditorium, May 15, 16 and 17.

Sixty-two different agencies connected with civilian defense took part in this ambitious Exposition.

Demonstration booths filled the lower floor and the foyer of the Auditorium. Doctor Fred B. Clarke was director of these demonstrations, which included everything from methods of extinguishing incendiary bombs to the operation of blood banks.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Dwight H. Murray, Napa; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

More than 40,000 citizens of Long Beach visited the Auditorium during the three days of the show and obtained practical first hand information that prepared them better to coöperate with the constituted authorities in the program of civilian defense.

Capacity audiences of 4800 witnessed each of the four stage presentations given in the Convention Hall of the Auditorium. The principal feature of this presentation was a two-act play, written and directed by S. K. Cochems, Executive Secretary of the Los Angeles County Medical Association, and entitled, "It May Happen Here."

The first act of this play presented a typical Long Beach home during an air raid, which ended with several typical casualties within the home and offered the opportunity to demonstrate what should and should not be done within the home during a raid. Members of the Community Players of Long Beach made up the cast for this act.

The second act presented a typical Long Beach Casualty Station where the casualties developed in act one were taken care of. The following Doctors of Medicine acted the part of casualty station physicians in the second act: Drs. Arthur Buell, Ward Hannah, R. Brisbine, Walter N. Caseley, H. A. MacMillan, and C. C. Cole.

Because of the large size of the Convention Hall, the greater part of the acting was pantomime with rather elaborate sound effects. Mr. Cochems, as commentator interpreted this pantomime, in terms of educational value to the audience.

The Long Beach Home Defense Show received, naturally, a great deal of important publicity in Long Beach. The wire services, recognizing this show as something new in civilian defense programs, carried the story far and wide throughout the country.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Postgraduate Institutes on Industrial Hygiene

(COPY)

WELFARE DIVISION, M.L.I.C.
William P. Shepard, M. D.
Assistant Secretary
Pacific Coast Head Office
600 Stockton Street, San Francisco, California

June 16, 1942.

George H. Kress, M. D.,
Secretary, C.M.A. Postgraduate Committee,
San Francisco, California.

Dear Doctor Kress:

(1) This is written in my capacity as Chairman of the Educational Committee, Western Association of Industrial Physicians and Surgeons, and reports to you progress to date on our proposed series of special Institutes on Industrial Hygiene to be held throughout the State for the benefit of physicians in industry.

You will recall that we planned to have these institutes sponsored jointly by the California Medical Association Committees on Industrial Hygiene and Postgraduate Activities; by the California State Department of Health; and by the Western Association of Industrial Physicians and Surgeons.

(2) Doctor Bertram P. Brown, Director, State Department of Health, has approved our proposed budget and forwarded it to the United States Public Health Service. We have every reason to think that this item will be approved, but cannot be certain until about July 10. Meanwhile, however, we are proceeding with all possible details.

(3) Since there is great urgency in this matter, we hope to have the series of institutes take place between August 3 and 12, inclusive. A tentative schedule is enclosed.

(4) We are already informed of the availability of Doctor Carey P. McCord, Medical Advisor, Chrysler Corporation, Detroit, and have a tentative acceptance from Doctor Leroy U. Gardiner, Director, the Saranac Laboratory, New York. We also expect the assistance of either Mr. Donald E. Cummings, Director of Industrial Hygiene, Colorado Medical School, an industrial hygiene engineer of national prominence, or Mr. J. J. Bloomfield, Chief Industrial Hygiene Engineer, United States Public Health Service, Washington, D. C. In addition, the faculty will include Doctor Robert T. Legge, Professor of Hygiene, University of California; Doctor Harold T. Castberg, Chief of Industrial Hygiene Service, State Department of Health; Mr. Carl Frey, State Industrial Compensation Board; a leading traumatic surgeon from each area; a leading industrialist, and a local engineer.

(5) May we rely on you to send notices of these meetings over the name of the Committees on Postgraduate Activities and Industrial Hygiene to County Society members in the counties surrounding each meeting place? We can discuss the exact mailing list and form of the invitation any time at your convenience.

(6) Since there is every reason to anticipate that this program will go through as planned, would you care to make some mention of it in the forthcoming issue of CALIFORNIA AND WESTERN MEDICINE? Please let me know if you wish further information.

Sincerely yours,

(Signed) W. P. SHEPARD, M. D.,
Chairman, Educational Committee,
Western Association of Industrial
Physicians and Surgeons.

(COPY)

State of California
DEPARTMENT OF PUBLIC HEALTH
Sacramento

June 29, 1942.

The Members of the County Medical Societies,
Addressed.

Dear Doctors:

This is a preliminary announcement to inform you that plans are under way for a series of special Institutes on Industrial Medicine, one of which will be held in your locality on the date shown below. They are sponsored jointly by the Committees on Postgraduate Activities and Industrial Practice of the California Medical Association; the Western Association of Industrial Physicians and Surgeons; and the California State Department of Public Health.

These institutes are intended to assist physicians devoting part time or full time to medical practice in industry. They will be short, concentrated sessions, occupying only one afternoon and evening, presenting several leading national authorities with opportunity for discussions and questions. Enclosed is a sample program, still in tentative form, but illustrating the type of session.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

This is a coöperative endeavor for the benefit of our country. With younger physicians being called into the armed forces, more of the older men will be called into industry. Great opportunities lie in this field since the health of the worker is as important to victory as the health of the soldier. Many physicians will wish to brush up on industrial medicine and this is their opportunity to do it. Even though it may conflict with one afternoon's office hours, we hope no one interested or engaged in this field will miss this opportunity. There is no expense involved except the price of the dinner which will be nominal.

Please call these institutes to the attention of your interested members. Exact meeting place will be announced later. The schedule is as follows:

August 18—San Francisco.
August 19—Crockett.
August 21—Oakland.
August 24—San Diego.
August 26—Los Angeles or vicinity.
August 27—Glendale.
August 28—Huntington Park.

About a month preceding each meeting, Doctor Harold T. Castberg, United States Public Health Service, Acting Director, Industrial Hygiene Service, State Department of Health, will call on the President and Secretary of the county society in which the meeting is to be held to discuss details and arrangements. Your assistance and coöperation will be deeply appreciated.

Sincerely yours,

BERTRAM P. BROWN, M. D.,
Director of Public Health,
State Department of Public Health.

GEORGE H. KRESS, M. D., *Secretary of Committee on Postgraduate Activities,*
California Medical Association.

BENJAMIN M. FREES, M. D., *President,*
Western Association of Industrial Physicians and Surgeons.

* * *

SUGGESTED PROGRAM

2:00 p.m.—*Opening of the Institute*
President of County Medical Society

2:10 p.m.—*Introduction*
Purposes and methods of the Institute—Sponsors and Participants. General Field of Industrial Hygiene and its values to practicing physicians.
Robert T. Legge, M. D.

2:25 p.m.—*The Conservation of Industry's Man Power*
Specific instruction about the general field of medical relationships in Industry; the part played by the practicing physician as an advisor to industrial management in organizing and administering a full-time or part-time medical department.
Carey P. McCord, M. D.

2:50 p.m.—*Industrial Hygiene and War Production*
Mr. Donald E. Cummings or
Mr. J. J. Bloomfield

3:05 p.m.—*Pulmonary Diseases in Industry*
Mr. Donald E. Cummings

3:25 p.m.—*Occupational Diseases in California*
With special references to diseases common in the locality of the Institute; demonstration of apparatus and methods used in making an industrial survey.
Harold T. Castberg, M. D.

3:55 p.m.—*California Industrial Accident Commission*
Mr. Carl Frey

4:15 p.m.—*The Surgical Management of Industrial Injuries*
Doctor Howard (North)
Doctor Frees (South)

4:45 p.m.—*General Discussion*

6:30 p.m.—*Informal Dinner*

8:00 p.m.—*Health in Industry*
Colonel Clarence M. Young,
Pan American.

8:20 p.m.—*Health Problems of Women in Industry*
Carey P. McCord, M. D.

8:40 p.m.—"Save a Day"—U.S.P.H.S. new motion picture

9:00 p.m.—*General Panel Discussion and Question Box*
Carey P. McCord, M. D.
Harold T. Castberg, M. D.
Mr. Donald E. Cummings or
Mr. J. J. Bloomfield
Leroy U. Gardiner, M. D.
Mr. Carl Frey
Doctor Howard or Doctor Frees
Robert T. Legge, M. D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

President Hund's Address: At Annual Session*

As representative of the Woman's Auxiliary to the California Medical Association, I greatly appreciate the privilege of the floor for these few minutes.

The doctors of the California Medical Association have been very kind to the Auxiliary, but I feel that some do not quite understand our aims and objectives, and the things that we are trying to accomplish.

Where the Medical Societies have asked the County Auxiliaries to carry on some definite work, it has made for a stronger Auxiliary and a better friendship between the women and among the doctors themselves.

I ask you, doctors, who live in sections where there are no County Auxiliaries, to consider us seriously. Look into our aims and objectives, and realize that this is an unselfish organization.

Our membership has increased in spite of the fact that many doctors have been called into the service, which often has necessitated change of residence by their wives. There are 2,142 members to date, and three new Counties have been organized, Inyo-Mono, Mendocino-Lake and Siskiyou. This leaves eight Medical Societies without Auxiliaries.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

* Address of Mrs. Harry O. Hund, President of the Woman's Auxiliary to the California Medical Association. Given at the first general session of the California Medical Association, Del Monte, May 4, 1942.

To the Advisory Council of the California Medical Association, and Mr. Hunton, I am truly grateful; for they have been most helpful and ready to give kindly advice whenever we called upon them.

Now, I would like to refer briefly to some of the activities we have carried on during the past year.

Due to the war emergency, many projects have had to be added to those which have been carried on during previous years.

Work vital to Civilian and Home Defense, and Red Cross had to be taken up and carried on.

A "survey" of all of our members has been made classifying them into four groups:

1. Those who have had training in nursing.
2. Those who have had training in clerical work, medical secretarial work, nutrition, anaesthesia, x-ray and other special work.
3. Those who have had no training, but who would be interested in First Aid, Nurses Aid and Chemical Warfare.
4. Those who have had training in foreign languages, and would be willing to work with State and Federal Agencies.

Each Auxiliary is to keep a file of this data, which we hope will be of benefit to the Medical Profession in case of an emergency.

Having speakers on "Nutrition for Health Defense" was stressed, and was publicized to lay organizations.

We aided with the procurement of signatures for the Basic Science Initiative, but regret that the result was not better; a cause being that the petitions were sent out to us too late and in several cases the Auxiliaries did not receive them at all.

In Defense Work:

Fully 95 per cent of the Auxiliary members are active in Red Cross, Civilian Defense and all branches of the war emergency work.

Up to 20,000 hours have been given by three counties to Red Cross work.

A total of 20 counties report that Auxiliary members are instructors and heads of Red Cross units.

Some 15 Auxiliaries have planned for a work-day each week at the local Red Cross chapters.

A total of 3,980 hours have been given for work at the blood banks.

One county donated $114.00, secured 250 donors and took over the blood bank. Another county gave 2,000 hours at their blood bank. The members of one of our smaller and newer counties have established a blood bank, and are assisting the doctors in its operation.

$750.00 has been given for Medical Scholarships.
$441.13 has been donated to Red Cross and War Relief.
$200.00 has been given to Health Agencies.
$150.00 to Hospitals and Sanitariums.

Apart from the Auxiliaries providing programs and entertainment for the men in the service outside of the Hospitality Houses, they have taken over specified days at the U.S.O. Houses, and sent Christmas trees, food and books to them.

Our members have been asked to interest lay people in the radio broadcast sponsored by the American Medical Association, "Doctors at Work."

The work on the Control of Cancer has gone ahead under the direction of the State Chairman.

Three Auxiliaries have reached their quota for Hygeia and one received honorable mention.

This year, for the first time, we have had a State Medical Benevolence Chairman. The problem of raising funds was placed before the Auxiliaries and the result has been gratifying.

Los Angeles County has contributed $276.00 to the Physicians' Aid of Los Angeles, but the rest of the counties have sent their contributions directly to the State Auxiliary.

Before closing, I wish to present, in the name of Auxiliary, this draft for the sum of $735.00 to you, Dr. Rogers, as President of the California Medical Association, to be used as the Association may see fit for its Medical Benevolence Fund.

* * *

County Auxiliary News Items

Humboldt County.—The last meeting of the season was held by the Humboldt Auxiliary on June 1st, at the home of Mrs. B. M. Marshall.

Mrs. David McInturff, treasurer, gave a report on the proceeds collected from the play readings, which were given by Mrs. Gordon Manary to raise funds for the American Red Cross War Relief.

The week of July 6th was chosen as the time in which the Auxiliary members will act as hostesses to the local U.S.O.

The following officers were elected for the year 1942-43: Mrs. John S. Chain, Jr., President; Mrs. B. M. Marshall, Vice-President; Mrs. Max Todd, Secretary; and Mrs. Walter W. Dolfini, Treasurer.

* * *

Los Angeles County.—The last luncheon meeting of the year of the Woman's Auxiliary to the Los Angeles County Medical Association was held Tuesday, May 26th, in the County Medical Building.

Guests of honor were Dr. William R. Molony, President of the California Medical Association; Dr. Lowell Goin, Speaker of the House of Delegates; and Dr. Elizabeth Hohl, Chairman of Physicians' Aid Association.

A check for $277.00, procured by voluntary contribution of Auxiliary members, was presented to Dr. Hohl for the Physicians' Aid Fund.

New officers were elected and installed in an impressive ceremony, and flowers, brought by the members from their own gardens, and arranged, decorated the luncheon tables.

* * *

San Diego County.—San Diego County Auxiliary is proud of the five women elected to serve on the State Board for the coming year. Mrs. F. G. Lindemulder will assume the presidency of the State Board.

On Tuesday, May 12th, Past Presidents of the Auxiliary, as well as recently-elected State Officers from the San Diego Auxiliary, were honored at luncheon at the University Club.

* * *

San Francisco County.—The May meeting of the San Francisco County Medical Auxiliary was an important one, in that it was the day on which the new officers were installed for the year 1942-1943. Mrs. J. C. Geiger, a Past President, installed the new officers with a very gracious talk on the accomplishments of the Auxiliary to date. President, Mrs. Raleigh Burlingame; First Vice-President, Mrs. William Newman; Second Vice-President, Mrs. Frederick Fellows; Treasurer, Mrs. Paul Michelson; Recording Secretary, Mrs. Harold Rosenblum; Corresponding Secretary, Mrs. Sydney Shipman. After this ceremony was completed, the retiring President was presented with a corsage as a gesture of appreciation for the great work which she has done in the year. Doctor Chauncey D. Leake, Professor of Pharmacology, University of California, spoke in a very interesting and informative way on War Gases.

The Auxiliary was requested by a group of the Medical Society, interested especially in nutrition, to have an additional meeting this year to concern itself with this vital subject. The meeting will be on Tuesday, June 9th, and the speaker will be Doctor Ann Purdy, Chairman

of the San Francisco Nutrition Council. Her subject will be "Nutrition." Miss Hazel Stevens, national authority on Posture, will speak on this subject. Guests invited are the wives of doctors at present in the armed forces around San Francisco. Tea will be served.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (64)

Alameda County (10)

John R. Booth, *Oakland*
Ellen Brown, *Berkeley*
George D. Brown, *Oakland*
George T. Honaker, *San Leandro*
Jonas J. Moyer, *Oakland*
Fenton Parker, *Oakland*
Walton Prescott, *Oakland*
John Stewart, *Oakland*
A. Ralph Thompson, *Berkeley*
John M. Ward, *Oakland*

Inyo-Mono County (1)

Walter R. Schatz, *Death Valley*

Los Angeles County (24)

Alan Calder Adams, *Beverly Hills*
Lewis H. Athon, *Los Angeles*
Samuel C. Benadom, *Beverly Hills*
Herschel S. Burns, *Los Angeles*
James Willoughby Burton, *Los Angeles*
Don McCauley Curtis, *Los Angeles*
Clarence Arnold Dahl, *San Pedro*
Roger John Dugan, *Los Angeles*
Edward Alfred Franklin, *Los Angeles*
Victor Goldberg, *Long Beach*
Dell Dean Haughey, *Los Angeles*
Earl Granville Longley, *Long Beach*
Saul Moss, *Los Angeles*
Rudolph Woldemar Mueller, *Los Angeles*
A. Victor Nasatir, *Los Angeles*
James Edgar Nichols, Jr., *Glendale*
Harold Owens, *Los Angeles*
John Lawson Saur, *Glendale*
Ralph Varian Sloan, *Glendale*
Erwin Edward Stephens, *Los Angeles*
John Daniel Stroud, *Pomona*
Robert Grant Thornburgh, *Long Beach*
William B. Wenz, *Lynwood*
Joseph B. Williams, *Los Angeles*

Sacramento County (5)

Abe E. Berman, *Sacramento*
George E. Chappell, *Sacramento*
Donald A. McKinnon, *Sacramento*
William R. Murphy, *Sacramento*
Kenneth E. Overholt, *Folsom*

San Bernardino County (1)

Wayne M. Caygill, *Lake Arrowhead*

San Francisco County (14)

William G. Barrett, *San Francisco*
Kenneth L. Elges, *San Francisco*
Olive F. Erickson, *San Francisco*
Gerald G. Gill, *San Francisco*
William A. Gorman, *San Francisco*
Alexander Gradow, *San Francisco*
James A. Hamilton, *San Francisco*
Emily L. Koeniger, *San Francisco*
Sanford E. Levy, *San Francisco*
Stanley Louie, *San Francisco*
Frank Norris, *San Francisco*
Henry William Scott, *San Francisco*
Clement A. Tavares, *San Francisco*
John B. Thielen, *San Francisco*

San Joaquin County (1)

Virginia Wright, *Stockton*

Santa Clara County (6)

Herbert T. Browne, *Palo Alto*
Carl O. Carlson, *Ft. Ord*
Ernest F. Elmore, *San Jose*
Philip J. Jordan, *San Jose*
Vasco A. Salvadorini, *San Jose*
W. Elwyn Turner, *San Jose*

Shasta County (2)

Charles William Brown, *Redding*
Leonard Katz, *Burney*

Transfers (6)

Maurice F. Stock, from Fresno County to Los Angeles County
Denson Basil Wheelis, from Riverside County to Los Angeles County
Victor Hart, from Siskiyou County to Alameda County
Albert Velarde, from Lassen-Plumas-Modoc County to Alameda County
William A. Richardson, from San Bernardino County to Los Angeles County
George E. Webster, from Sonoma County to Los Angeles County

Retired Members (5)

Maynard C. Harding, *San Diego County*
E. Jay Clemons, *Los Angeles County*
Arthur A. Libby, *Los Angeles County*
William Owen Sheller, *Los Angeles County*
Leon H. Watkins, *Los Angeles County*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Dyke, Louis Henry. Died at Oakland, June 2, 1942, age 65. Graduate of the Oakland College of Medicine and Surgery, 1916. Licensed in California in 1916. Doctor Dyke was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Gunderson, Harley James. Died at Los Angeles, May 29, 1942, age 53. Graduate of Northwestern University Medical School, Chicago, 1911. Licensed in California in 1926. Doctor Gunderson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Hall, Giles S. Died at San Francisco, June 4, 1942, age 73. Graduate of Rush Medical College, University of Chicago, 1897. Licensed in California in 1898. Doctor Giles was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

McCullough, Frank Edward. Died at Sacramento, June 4, 1942, age 63. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1879. Licensed in California in 1906. Doctor McCullough was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

Shafor, Harry Andrew. Died at Westwood, May 27, 1942, age 66. Graduate of Eclectic Medical College, Cincinnati, 1899. Licensed in California in 1926. Doctor Shafor was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Pearson, Charles E. Died at Turlock, May 23, 1942, age 64. Graduate of Kentucky School of Medicine, Louisville, 1898. Licensed in California in 1918. Doctor Pearson was a member of the Stanislaus County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Clark, Vernon Greene. Died at San Diego, June 6, 1942, age 69. Graduate of Missouri Medical College, St. Louis, 1896. Licensed in California in 1906. Doctor Clark was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES

George Chauncey Wrigley, M. D.
1884—1942

Dr. G. C. Wrigley, for thirty years a practising physician and surgeon in Sonora, California, and a member of the San Joaquin County Medical Society, was found dead on the floor of his office Friday morning, May 1. He had failed to return home the night before, and his wife became anxious, as he had been suffering from a heart ailment for several weeks. Accompanied by his office nurse, she discovered the body; where it was evident that, in falling, he had struck his head on an iron operating table, causing a fracture of the skull.

Dr. Wrigley was a native of New Brunswick, Canada, and spent his earlier life in Eureka, California, where he went through the public schools. He was graduated from the College of Physicians and Surgeons of San Francisco in 1909; and after a short period of practice in San Francisco, moved to Sonora where he has been continuously engaged in professional work, except for a period during the first World War, when he served in the medical corps.

Dr. Wrigley, during his long residence in Sonora, earned the confidence of many people who would wait patiently for his return to practice, since they felt no one else could quite take his place.

He is survived by three daughters and a son, who is now in the armed forces of the United States, three brothers and two sisters, living in Eureka, California.

DEWEY R. POWELL, M. D.

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Louis Montrose Haight, M. D.
1868—1942

On Monday morning, April 27, Louis M. Haight, one of the oldest members in our San Joaquin County Medical Society, was found dead in bed, having passed away quietly in his sleep. Dr. Haight had spent the previous day, Sunday, working about his garden, and had enjoyed a family dinner before retiring. His son spoke to him at 7:00 o'clock A.M. and apparently he had had a usual night's rest; but at 9:30 he failed to respond to a call to breakfast, having passed away.

Dr. Haight was born in Alameda, California, October 7, 1868. He was the son of Henry Huntley Haight, who at that time was Governor of the State of California, and served in that capacity from 1867 to 1871. One of the principal thoroughfares in San Francisco, Haight Street, was named in honor of the Governor.

After preliminary education in the public schools of Alameda, Dr. Haight attended Yale University, where he graduated with the Class of 1889. He returned to California, and in 1897 was graduated from the College of Pharmacy of the University of California. After following that profession for three years, he entered the Cooper Medical College and was graduated with the Doctor of Medicine degree in 1903.

He spent several years in the City and County Hospital in San Francisco under private practice, and moved to Stockton in 1906 to devote his time to ranching interests. In 1917, when a number of the medical men in practice in Stockton volunteered their services in the armed forces of the United States, Dr. Haight resumed his medical career, working for a while in the offices of Dr. Ellis Harbert. He later continued practicing by himself and was active up to the time of his death at 73 years of age.

Dr. Haight was married in 1900 and his widow and three sons survive. His oldest son, Cameron, is now professor of Chest Surgery at the University of Michigan Medical School at Ann Arbor, and has made a splendid record in his chosen specialty. His second son, Herbert, is manager for the Shell Oil Company in Seattle, Washington. His third son, Huntley, is employed by the United States Government in Stockton.

At all times Dr. Haight was most courteous and considerate as a gentleman. It was my privilege to have his friendship for a period of thirty years, and for many years recently he has been my neighbor. Through all the twenty-five years in which he resumed the practice of medicine, his greatest pleasure was still to watch things grow, and his garden was his delight. He was also a great lover of music, and thoroughly enjoyed singing in various men's choral groups.

He will be sorely missed by his multitude of friends and the many patients who placed their confidence in his judgment.

DEWEY R. POWELL, M. D.

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Giles Starke Hall, M. D.
1869—1942

Dr. Giles S. Hall was born March 3, 1869, on a farm north of Ionia, Michigan. He died in the Southern Pacific General Hospital in San Francisco, June 4, 1942.

He attended public school in Ionia, the Maryland Military Academy, and completed his medical course at Rush Medical in 1897.

Dr. Hall first came to Los Angeles in 1887, then returned East to complete his education. He began the practice of medicine in the County Hospital at Tombstone, Arizona; later became surgeon for the Phelps-Dodge Company, and was licensed to practice in the state of Sonora, Mexico, where he spent four years.

He married Louise Hobbie of Omaha, Nebraska, in 1901. They lived in Mexico until 1903, at which time they returned to Los Angeles where the doctor soon became associated with the Los Angeles and Pacific Electric Railways, and in 1904 with the Southern Pacific Company. For many years he has been Assistant to the Chief Surgeon in charge of the Los Angeles office of the Southern Pacific Medical Department.

Dr. Hall was a man who kept in close touch with the developments of modern medicine; he was a member of the Los Angeles County, California State, and American Medical Associations. He was Past President of the Pacific Association of Railway Surgeons. He enjoyed life and was greatly beloved by his family and his associates. His keen sense of humor was in daily evidence in his contact with friends and patients, and those of us who have been associated with him for many years will greatly miss him.

RUSSELL W. STARR, M. D.

OBITUARIES

Vernon Greene Clark

1872—1942

Dr. Vernon Greene Clark, county hospital assistant superintendent and a San Diego resident for 36 years, died of a heart attack on June 6th.

Born in Steelville, Mo., in 1872, Dr. Clark was graduated from the Washington Medical college in St. Louis, Mo. After taking several postgraduate courses, he went to Colorado, where he practiced in many mining camps.

Dr. Clark came to San Diego in 1906 and began a private practice. He served in World War I as a lieutenant commander, U.S.N. After the Armistice, he resumed his private practice, continuing it until three years ago, when he joined the county hospital staff. He was a former president of the San Diego County Medical Society.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

November, 1940	19,990
May, 1941	27,057
November, 1941	32,199
May, 1942	38,061

The job of converting our full coverage contracts over to the two visit deductible has begun. This is in line with the policy which was recently laid down by the Board of Trustees of California Physicians' Service.

As previously reported, the full coverage contract has not been successful in producing an adequate return to the physician. Our experience with the two-visit deductible has shown that some of the human factors that have destroyed the full coverage are taken care of.

Several groups have already been contacted, and we have had very interesting reactions from the people involved. It is interesting to note that the beneficiary members of C.P.S. are just as anxious to make the plan go as the medical profession is, and are perfectly willing to abide by the changes that we have suggested.

Since we will be contacting every group throughout the state, there will be an opportunity that we have not had in the past of reacquainting these groups with the objectives of the medical profession, and reëstablishing satisfactory public relations, which is one phase of our activities with which, to date, we have been able to do very little.

It is felt that with the proper understanding on the part of the groups, and with the increasing return to the physician, many of the basic troubles of C.P.S. will automatically disappear.

* * *

Tulare Bureau Members Told of Hospital Plan

Visalia (Tulare Co.), May 30.—Dr. H. B. Rector of Fresno, field representative for the California Physicians' Service, which is negotiating a contract with the Tulare County Farm Bureau for treatment of bureau members, further outlined the proposed plan during the week.

Dr. Rector said the annual dues for one person is $22.50; for two in a family, $36; three, $45; four, $51; five, $54.50, or six or more, $57.

List of Services

The services offered in the contract follow:

All medical and surgical services that may be necessary as a consequence of illness or injury. In the office of a California Physicians' Service professional member. In the home when necessary. In the hospital when necessary.

All x-ray and laboratory examinations necessary in the opinion of the attending professional member are included.

Obstetrical services.

Chronic ailments and/or conditions, unless contagious or infectious and acutely emergent, shall receive only such services as are necessary to establish prognosis or estimate of ultimate value of treatment; except:

Can Extend Treatment

In the cases of members who have not reached their nineteenth birthday upon favorable prognosis the medical director of the service shall authorize such continued treatment as he deems necessary.

In the cases of members who have passed their nineteenth birthday and who are wage earners of the family, chronic conditions which interfere with earning capacity may receive necessary care upon the approval of the medical director of the service.

Service Is Limited

Surgical service for each member who has passed his nineteenth birthday shall be limited to surgical service for such conditions as are proximately caused after 12 o'clock noon of the day upon which the service issues a certificate of beneficiary membership to him, and then only after such consultation as the medical director of the C.P.S. may require.

The farm bureau also is contemplating a contract with the Hospital Service of Southern California. The hospital rates are:

A maximum of $24 for three or more members of a family annually to a minimum of $7.80 for a single male and $9.60 for a single female.

Hospital Care Provided

The hospital care is provided in any of the sixty-one member hospitals in Southern California as follows:

Twenty-one days per year for each particular physical disability arising from a separate and distinct cause. Services will be provided in a room of three or more beds.

All meals and dietary services.

General nursing care.

Use of operating room as often as needed.

Surgical and anaesthetic supplies.

Splints, casts, dressings.

All necessary drugs except biologics, endocrines and vitamin preparations, and oxygen.

Existing conditions fully covered.

Obstetrical cases covered with a maximum of $5 per day for a period of ten days hospitalization after ten months waiting period.

Childbirth Provisions

Obstetrical care is provided only to wife under a family contract and after ten months' membership. Hospital care does not cover diseases declared by law to be quarantinable, pulmonary tuberculosis after diagnosis, mental disorders nor diagnostic or rest cure hospitalization.

Surgical service for obstetrics is furnished only for ectopic pregnancies and Caeserean sections, when medically necessary.

Neither the hospital service nor the surgical service covers conditions already protected by any workmen's compensation or employers' liability laws or conditions caused by war.—Fresno *Bee*, May 31.

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Farm Health Association in Second Year

The North Coast Farmers' Health Association began its second year of operation on June 1. This coöperative health program was organized last year under the leadership of the Farm Security Administration, by a group of farm families in Sonoma, Lake, and Mendocino Counties. An agreement was made with the California Physicians' Service to promote medical care and hospitalization for the members at a fixed prepaid fee. Seventy-five families joined the association. A similar agreement has been signed for this year, with about the same number of families participating. At membership meetings held last month, directors elected were S. C. Farwell of Santa Rosa, Don Milliken of Cotati, Helmuth Tornoe of Sebastopol, Mrs. William Peters of Hopland, and Glenn Dickey of Lakeport.

Although the membership year started June 1, additional applications will be received up to June 25. Any farm family, whose net income is less than $2000.00,

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† Address: California Physicians' Service, 153 Kearney Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of non-profit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

and who wishes the assurance that its medical needs are provided for, is invited by the directors to join the association. Full details may be obtained from any of the directors, or from the local office of the Farm Security Administration, 501 Rosenberg Building, Santa Rosa.—Healdsburg *Tribune and Enterprise*, June 11.

* * *

Signup Date Is Set For Rural Hospitalization

Oroville (Butte Co.), June 8.—Claude Lane of Gridley, President of the Butte County Farmers Health Association, has announced that June 13th has been set as the last date upon which new members can join the group.

The association, Lane said, has started its second year of operation in Butte County, and through the California Physicians' Service, has provided almost complete medical, surgical, obstetrical and hospital care for low income farm families who are members. The member has the privilege of selecting her own doctor. To be eligible, Lane said, the farm family must make at least 50 per cent of its income from farming and farm labor, and the net income must not exceed $2000.00.

Lane said that after June 13th, there will be no opportunity of joining the association until June, 1943.—Sacramento *Bee*, June 8.

REVISED LIST OF REPORTABLE DISEASES

(Reportable to the California State Board of Public Health)

Reportable Only:

Anthrax
Botulism—if commercial product notify State Department of Health at once.
Coccidioidal Granuloma
Dengue—keep patient in mosquito-free room.
Epilepsy
Food Poisoning
Glanders—report by phone or telegraph.
Jaundice—infectious or epidemic types.
Malaria—keep patient in mosquito-free room.
Pneumonia—specify type of pneumococcus, if known.
Relapsing Fever
Pheumatic Fever
Rocky Mountain Spotted Fever
Tetanus
Trichinosis
Tularemia
Undulant Fever

Reportable and Subject to Isolation:

Epidemic diarrhea of the newborn (in institutions)
Chickenpox
Dysentery—Amoebic
Dysentery—Bacillary—specify type, if known.
German Measles
Influenza
Measles
Mumps
Ophthalmia Neonatorum
Psittacosis
Rabies—in animals. Use special card.
Rabies—in humans.
Septic Sore Throat (in epidemic form).
Trachoma
Tuberculosis—use special card.
Whooping Cough
Syphilis—use special card.
Gonorrhea—use special card.
Chancroid—use special card.
Lymphopathia Venereum—use special card.
Granuloma—Inguinale—use special card.

Reportable and Subject to Quarantine and Placarding:

Cholera—report by telephone or telegraph to State Department of Health.
Diphtheria
Encephalitis (Infectious)—specify type if known.

NOTE: This means all forms of acute encephalitis such as St. Louis type, equine type, and any other epidemic form occurring in California.

Leprosy
Meningitis (due to the meningococcus).
Paratyphoid Fever—specify type A or B.
Plague—report by telephone or telegraph to State Department of Health.
Acute Anterior Poliomyelitis
Scarlet Fever
Smallpox
Typhoid Fever
Typhus Fever
Yellow Fever—report by telephone or telegraph to State Department of Health, State Office Bldg., Sacramento.

DYSENTERY CARRIERS

Since it is only slightly absorbed into the blood stream, succinylsulfathiazole, a sulfonamide compound, is much less likely to produce severe toxic or poisonous reactions than sulfaguandine in the treatment of dysentery carriers, William M. M. Kirby, M. D., and Lowell A. Rantz, M. D., San Francisco, report in *The Journal of the American Medical Association* for June 20. They found succinylsulfathiazole to be as effective in treating dysentery carriers as sulfaguanidine and is ineffective in treating typhoid carriers.

WARN HIGHLY FATAL FUNGUS DISEASE IS NOT CONFINED TO CALIFORNIA

Coccidioidal granuloma in human beings is a chronic, highly fatal fungous disease affecting the lungs, skin, lymph nodes, bones, meninges, the organs of the chest, and other body tissues. In a paper in *The Journal of the American Medical Association* for July 4 on the incidence of the disease in man and animals, George W. Stiles, M. D., and Charles L. Davis, D.V.M., Denver, warn that, while the disease "has been considered peculiar to California, its appearance both in man and in animals from other localities indicates that the malady is either spreading or has not heretofore been recognized. Coincident with this disease in man, an increasee is noted in the number of cases occurring in lower animals. In regions in which man has acquired infection, cattle, dogs, sheep, wild rodents and possibly other animals may harbor the fungus.

"Coccidioidal granuloma appears to be acquired by inhaling spores of the fungus, by cutaneous [skin] infection through wounds or rarely through the gastrointestinal route."

EFFECTIVE TREATMENT FOR AN EYE DISEASE

The direct application of a 5 per cent ointment of sulfathiazole or sulfathiazole sodium was effective in causing rapid healing in 11 of 15 cases of inclusion conjunctivitis in infants, children and adults, Phillips Thygeson, M. D., and William Stone Jr., M.D., New York, report in *The Journal of the American Medical Association* for May 30. In 10 of the 11 cases the virus could no longer be found after the third day of treatment. Two of the remaining 4 cases, 1 in a child and 1 in an adult, required supplementary treatment by mouth; the remaining 2 cases, both in infants, failed to heal until the mothers learned to employ the medication properly. There were no recurrences. Untreated cases of the disease take from four to six months to heal.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association, San Francisco. Date of 1943 Session not yet decided.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Few things are more important to a community than the health of its women. If strong is the frame of the mother, says a proverb, the son will give laws to the people. And in nations where all men give laws, all men need mothers of strong frames.—*T. W. Higginson.*

Opportunities for Physicians: Traumatic Surgery.—The Receiving Hospital Department for the City of Los Angeles has announced that many of their ambulance and hospital doctors have joined the armed forces. Doctors interested in emergency traumatic injury work should contact the Chief Surgeon, Dr. Wallace Dodge, at 1337 Georgia Street, Los Angeles, California.

Doctors of Medicine as Some Others See Them.—During recent years, the medical profession and its work, has been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest. Several of such excerpts follow:

* * *

Fewer Doctors.—Thousands of doctors are being called into military service, and from now on there will be fewer of them to care for our aches and pains. The fighting forces need them.

The list of doctors in Riverside and Riverside county—those within the military draft age—is growing smaller and smaller on the home front, and we are going to find it more and more difficult to be served.

There is little question of dependency, in the case of our doctors, because all doctors are commissioned officers, with salary sufficient to take care of families at home modestly but adequately.

Few of us appreciate how many physicians are being siphoned off into the armed forces and how great an added burden this imposes on the doctors who remain at home. A doctor who remains at home will be required to take care of a great many more patients, than in the past. We know the doctor will do his best. But there are only so many hours in the day and it will be up to the patients to help him along as much as they can.

Few realize that continued good medical service will depend on helping the doctor to conserve his time. The more time the doctor can save in traveling about to see his patients the more time he will have to treat them. Don't ask the doctor to make house calls when you are perfectly able to go to his office. Don't expect him to sit around and talk about extraneous matters. Don't try to turn a professional visit into a social occasion.

The American people are used to the best medical service on earth—and they will continue to receive that kind of service if they give due consideration to the fact that the doctor is one of the busiest of men.

Families with pioneering traditions will know what it is to get along with few calls from the doctor. They will be more careful about themselves and their children, under conditions which face them, and most of them will be better off for being too busy to worry about their small aches. No more easy care for trifling illness. They'll give themselves a first-aid treatment and go on from there. They'll have to.

What we must do is to listen carefully to the doctor's instructions, get them right the first time and follow orders accurately.—Riverside *Enterprise,* May 19.

Save Independent Medicine.—We do not hear much agitation for socialization of medicine these days. Our system of private medicine has been responsible for so many great achievements that demands for revolutionary changes are not given the support of thinking people.

However, proposals are occasionally made which, though they may seem superficially sound, would extend a measure of political control over medicine which would pave the way for socialization or regimentation of the doctor at some future date.

A recent example of that is found in the proposal that the Social Security Laws be broadened to make health

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† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

insurance compulsory for all workers and their families.

If this proposal were made into law, the doctor would have to look to the insurer, a branch of Federal government, for much of his livelihood. The insurer would determine the fees which he might charge and that, in turn, would determine the amount of time he could give each patient. The future of all doctors would depend, in part, on a bureau whose policies and personnel are directly affected by the ever-changing tides of politics. And, most important by far, if compulsory sickness insurance became a national policy, the logical next step would be the passage of a law making everything concerned with public health a function of the state. And that would be nothing more or less than socialized medicine.

If private medicine had failed, a case could be made for this. But the plain truth is that America has been a world leader in care of the sick and in medical discovery. The man with little or no money can command the finest medical talent, and the most famous doctors give much of their time to patients who cannot pay. What valid reason can there be for disrupting a system which has given the American people the finest average health on earth?—San Jose *Santa Clara County Review*, June 9.

Rationing Doctors.—The warning voiced to the American Medical Association the other day that the nation's civilian population must expect rationing of medical care will be seized upon by the confirmed heckler who likes to borrow trouble as a field for almost endless speculation over the practical difficulties of administering such a rationing program.

Will they give us so many calls a month, sick or well, he will wonder? Or will we be entitled to medical attention for only one ailment, with all the others left to run their natural course? And will there be special X-cards for hypocondriacs, ailing dowagers and congressmen? Will you have to prove you are essential to the war effort before you can get some attention?

The heckler who asks all these questions, of course, will be missing the essential point—which is that rationing of civilians for medical care, however accomplished, will be preferable to having to ration the armed forces.

The plain fact is that there aren't enough doctors to meet the needs of the army and navy, and to continue giving civilians the care to which they are accustomed. This was brought home rather sharply at the A.M.A. meeting, where it was estimated that 45,000 doctors will be required by the army alone before the end of the year.

Thus, it is the old story of civilians having to sacrifice the luxury of medical service that is not entirely necessary, so there will be enough to go around for essential needs.

We have no idea how the practical obstacles to rationing of medical care can be surmounted, but we have no doubt that some system can be found to handle civilian cases in the order of their importance instead of first-come-first-served if the situation becomes critical enough to warrant it.

And we would rather suffer through our minor aches and ailments without medical care, if we knew that by so doing we were making it possible for our over-worked family doctor to save the life of either a wounded soldier or one of the neighbor's children.—San Jose *Santa Clara County Review*, June 9.

Ready for Any Eventuality.—"The indications are that the needs of the Army, the Navy, public health and civilian populations can be met by scientific planning and complete coöperation without any deterioration in the quality of medical education and medical service," said the Journal of the American Medical Association, recently.

War makes heavy demands on American medicine. Thousands of doctors are being called to duty with the military forces. Tens of thousands of doctors are giving a part of their working time to the Selective Boards and other military and quasi-military agencies. Workers in arms industries will work longer hours at strenuous labors, and will require more medical attention than was necessary in peacetime. But, despite all this, experts in the field are convinced that American medicine will meet the crisis with complete success.

That is a fine testimonial to our system of private medicine. Nowhere else in the world are doctors given such rigorous training. Nowhere else in the world are there so many doctors. Nowhere else in the world has such astonishing progress been made against the bacterial killers. The average American is healthier than the average citizen of any other country. He lives a longer, happier life. And you can give American medicine much of the credit for that.

The American hospital system has kept pace with the medical progress. To meet wartime needs, increased hospital facilities are being planned in many regions. Those who guard this nation's health are doing a magnificent job—and they are ready for all eventualities.—Stockton *Pathfinder-Union*, May 15.

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Saga of the Small Town Doctor:

That, in brief, is the saga of all small town family physicians in America since this nation was founded. That, too, is the life story of the man whose soul has just departed and to whom this inadequate tribute is belatedly paid. He has done all of these things and more.

Somehow or other, this particular physician's grip upon the lives of his flock continued from the moment of the first pulse beat until they were laid to rest. Their attraction to him began in childhood and grew stronger with the years. Their faith in him grew with the passing of each day. So great was this faith that many seemed to defy the irresistible hand of fate in their final moments, expecting him to pull them through as he had done so many times before.

Physician, counselor, humanitarian, friend—this man was all these and more. His cheerful witticisms became legendary. His buoyant personality drove despair from sick rooms. His knack of accurate diagnosis, coupled with unerring treatment, gained for him prestige in his profession. His diplomatic frankness conveyed to others in a gentle manner the picture as his adroit, experienced eyes saw it, not as he would have preferred it to be. The families of the ill knew they could rely on this and acted accordingly.

This man was the friend of all. No one left him empty handed when it was within his power to help. His generosity was so proverbial that it was imposed upon. Such imposition, when known, brought forth no criticism from his lips. And yet, withal, he was a real he man, enjoying association with his fellowmen of all stations in life. No one was too lowly or too proud to be called by him a friend and in turn to call him a friend.

That the world is a trifle better for the life and deeds of this genuine physician would seem self-evident. That such men live on—forever—in the hearts of their fellowmen is likewise self evident. And that somewhere, somehow, someday—in that great beyond from whose bourne

no traveler returns—we shall be reunited by death, is the faith that sustains us in our moments of bereavement.—Merced *Sun-Star*, June 2.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Election of Trustees of the American Medical Association

Edward M. Pallette of Los Angeles Elected Trustee

Dr. William R. Molony, Sr., California, nominated for Trustee to succeed Dr. Arthur W. Booth, Elmira, N. Y., whose term has expired and who is not eligible, according to the By-laws, for reëlection, Dr. Edward M. Pallette, Sr., Los Angeles, and the nomination was seconded by Drs. Charles E. Mongan, Massachusetts; William Weston, Section on Pediatrics; James M. Hayes, Minnesota; Joseph F. Smith, Wisconsin; E. S. Hamilton, Illinois; Robert L. Anderson, Pennsylvania; Hilton S. Reed, New Jersey, and E. E. Barlow, Arkansas.

Dr. Thomas A. McGoldrick, New York, placed in nomination the name of Dr. Charles Gordon Heyd, New York.

It was moved by Dr. William A. Mulherin, Georgia, seconded by Dr. L. W. Larson, Section on Pathology and Physiology, and carried, that the nominations be closed.

The tellers spread the ballot and the Secretary announced that 139 votes had been cast, of which Dr. Edward M. Pallette, Sr., received 104 and Dr. Charles Gordon Heyd, 35. The Speaker declared Dr. Edward M. Pallette, Sr., Los Angeles, elected Trustee for a term ending in 1947, to succeed Dr. Arthur W. Booth. On motion of Dr. Thomas A. McGoldrick, New York, seconded by Drs. George W. Kosmak, New York, and Robert A. Peers, California, and carried, the vote for Dr. Pallette was made unanimous. . . . —From Minutes of Proceedings of A.M.A. House of Delegates, in *Journal of the American Medical Association*, June 27, 1942, page 731.

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Doctors Gather for A. M. A. Convention

Atlantic City, June 8. (INS).—With problems of the war paramount on the program, more than 13,000 delegates gathered today for the American Medical Association's annual convention.

Dr. Morris Fishbein, editor of the Journal of the American Medical Association, pointed to one of the chief war problems facing the physicians when he declared that 20,000 young doctors are needed for America's military service this year, in addition to the 22,000 already commissioned.—Pasadena *Star-News*, June 8.

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Atlanta Doctor Named A. M. A. Head

Atlantic City, N. J., June 12.—(AP).—Dr. James E. Paullin of Atlanta, Ga., will take office next year as president of the American Medical Association.

Dr. Paullin, chairman of the association's council on scientific assembly, was named president-elect yesterday by the A.M.A.'s house of delegates, ruling body of American medicine. He will succeed Dr. Fred W. Rankin of Lexington, Ky., who took over as president Wednesday night.

Dr. William J. Carrington of Atlantic City was named vice-president; Dr. Olin West of Chicago was reëlected secretary; Dr. Herman L. Kretschmer of Chicago was named treasurer; Dr. H. H. Shoulders of Nashville, Tenn., speaker of the house, and Dr. R. W. Fouts of Omaha, Neb., vice-speaker; Dr. Edward M. Pallette, Los Angeles, trustee.

The group decided to meet at New York in 1945. Next year's meeting, that of 1943, will be held in San Francisco. —Oakland *Tribune*, June 12.

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A. M. A. Distinguished Service Medal

Dr. Ludwig Hektoen Named by Association

Atlantic City, N. J., June 8.—(UP).—Dr. Ludwig Hektoen, 78, Chicago, won the American Medical Association's 1942 distinguished service award today for outstanding contributions in the field of medicine.

The award was announced by the association's house of delegates as the 93rd annual convention opened. Dr. Hektoen, leader in the field of pathology, is chairman of the advisory committee of the National Cancer Institute and chairman of the committee on scientific research of the A. M. A.

The award includes a citation and a medal and is the highest honor bestowed upon a member by the association. Dr. Hektoen had not arrived today for the convention, but is expected here tomorrow.—San Francisco *News*, June 8.

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Physicians Told of Discoveries at A. M. A. Meeting

Baldness and Virility

Atlantic City, June 9.—(AP).—A form of ammonia found in the common pitcher plant of Eastern swamps, one shot of which relieves certain types of deep-seated pain for days or weeks, was described to the American Medical Association here today.

Another report related that baldness in men was definite evidence of possession of an abundance of he-hormones. This finding was submitted to the association for the study of internal secretions, meeting in conjunction with the medical association.

The baldness report was by Dr. James B. Hamilton, Yale University School of Medicine. He found that men who had lost their normal supplies of male sex hormones tended not to become bald, even in families where baldness was the rule.

When some of these men were given male sex hormones, they started to lose their hair; stopped losing it when the hormone was taken away.

He concluded that two factors influenced baldness, one an inherited predisposition, the other the male hormone stimulation.—Oakland *Tribune*, June 9.

* * *

That Seashore 'Lift' Is Thalassotherapy; Says So 'Right Here'

Atlantic City, N. J., June 9.—(AP).—Did you ever wonder what's the name of that "lift" people get during visits to the seashore?

It's thalassotherapy.

Says so right in the American Medical Association's convention program.

Dr. Charles I. Singer of the Long Beach (N. Y.) Hospital has an exhibit on thalassotherapy at the convention.

His display is designed to show:

1. That 35,000,000 Americans take undirected vacations each year are motivated by "whom, vogue or hearsay" as to where's the best place to go.

2. That as a result they meet up with climatic changes which are either stimulating or sedative.

3. That many people who have chronic ailments may benefit by medical direction while they are basking at the seashore—especially children with catarrh, asthma, tuberculosis, rickets and retarded development; adults with neurasthenia, chronic arthritis and hay fever.

4. That it's a fallacy to say you get worse sunburns on a hazy day than a bright one.

5. That there's more iodine in the air at the shore.

6. That feet cut on shells at the seashore rarely become infected because the sun-baked sand is clean.

7. That sunstroke is rare on beaches, and heat prostration virtually is unknown because the infra-red rays are partly absorbed by the skin.

8. That thalassotherapy is the treatment of disease by a resident at the seashore, or by sun-bathing.—Oakland *Tribune*, June 9.

* * *

The Blood Bank, a Monument

Today the San Mateo county blood bank went into service on the grounds of the Junior college, a testimonial to the community coöperation of scores of individuals and firms and particularly of Union labor which sponsored the movement and did most of the pioneering.

The dedication today was marked by a public program in the spirit of the gift itself, where speakers told of its importance to the community and gave credit to those responsible for its being here. The audience was also introduced to the two persons symbolic of the blood bank itself and who, appropriately, volunteered to give the first blood. They were Mr. U. S. Simonds, Jr., of the Carpenters' Union and Miss Helen Chesebrough, of the San Mateo County Red Cross. Mr. Simonds first suggested the county blood bank, and his suggestion was taken up by Union labor. As its importance became evident the county and scores of individuals became interested, contributing what they could best give, whether money or material, service or labor.

The blood bank will be here and will be available to save the life of anyone in the county. The efficacy of blood plasma in saving life in case of violence or burns has long been known but was demonstrated beyond all doubt at Pearl Harbor when hundreds of boys who otherwise would have been doomed to a quick death, were saved and are even now back in the firing lines.

Opening of the blood bank is an important step in the medical history of the county.—San Mateo *Times and Leader*, May 23.

Hospital Note—Don't Linger

Oakland, Calif. (AP).—Hospitals here are trying to shorten the length of their patients' stay, to be better equipped for war emergencies. It is hoped to cut the average from ten to nine days, largely by dismissing maternity cases earlier than usual.

Private institutions are running virtually at capacity, owing to increased population springing from defense factories and partly to hospital service plans.—Monrovia *News-Post,* May 18.

* * *

Dr. Mark L. Emerson, county coroner of Alameda County, has filed his nomination papers in preparation for a reëlection campaign this year.

Dr. Emerson is a graduate of the University of California, former school director and health officer of the City of Oakland, former director of the Alameda County Mosquito Abatement District, and past president of the Alameda County Medical Association.

Elected four years ago, Dr. Emerson established the coroner's office in a county-owned building for the first time. During his four years in office he has established deputies in outlying communities and has improved the efficiency of the office.—Oakland *Tribune,* June 9.

* * *

Strong War on Plague Urged

Must Be Extended to Protect Army Camps, Officials Aver

Washington, June 4. (AP).—Public health officials testified before the house appropriations committee during hearings on the service's appropriation for fiscal 1943 that the fight against bubonic plague must be extended this year because of the need to protect army camps and to prevent the eastward spread of ground squirrels which carry the disease.

Dr. J. W. Mountin said that each year the service encountered about a dozen deaths from plague throughout the United States and that hunters and campers who shot the rodents could become infected.

He said the infection was known to exist among squirrels and other rodents in the 12 mountain and Pacific coast states.

Dr. Mountin said that if the rat population of the cities became infected, human deaths would become more numerous and he recommended the establishment of rodent-free zones around towns, cities and military establishments, saying such measures were especially urgent from a military point of view. He said plague-infected rodents had been found on the grounds or in the immediate vicinity of Fort Warren, Wyo.; Fort Wingate, New Mexico; McCarran Field, Nevada; Camp Hunter, Liggett, Calif.; Fort George Wright, Washington; Geiger Field, Wash.; Gowen Airfield, Boise, Idaho, and at the Pendleton, Ore., Airfield.—Ogden *Standard-Examiner,* June 4.

* * *

Birth Control Urged for WAAC Volunteers

Margaret Sanger Says Army Should Furnish Scientific Information to Protect Its New Corps

New York, June 3.—Now that Women's Army Auxiliary Corps, that has started recruiting, has ruled women who are going to have babies will be discharged from the Army, Mrs. Margaret Sanger, founder and honorary president of the Planned Parenthood Federation of America, says: "It is up to the Government to furnish Army women with scientific contraceptive information and not force them to rely on backfence gossip or folklore.

"This should not be made a religious issue. It should be as protective to a WAAC's security as vaccination secures her against smallpox," Mrs. Sanger said today.

"If the Army heads have allowed themselves to get into this position without thinking it through the whole way the dishonor is on their side and not on the woman's. In my estimation child-bearing is never a dishonorable function.

"I believe the WAAC is perfectly right in making the ruling. While some women even in the Army could carry a baby up to the eighth month without feeling any discomforting effects, they are few. The Army cannot pick and choose. It has to make a policy. If they let any one come in and have her babies it would be too insecure for the Government.

"It is up to the woman to decide whether she wants to go in the Army or have her baby. She has no right to do both. A woman should definitely make up her mind which she wants.

"Babies are not the problem of the woman's army in England because since 1932 women there have had access to birth control information," she said.

Mrs. Sanger believes that birth control advice should be given to those who need it most.

"The average married woman should have the right to get contraceptive information, but this should be given by the right authorities," Mrs. Sanger emphasized, and pointed out that three states, North Carolina, South Carolina and Alabama—now have birth control services as part of their state health control.

Dr. Pierce recalled that in 1937 the American Medical Association stated doctors had a legal right to give contraceptive information to women. Last fall in Washington, he stated, the Public Health Service agreed to consider child planning programs submitted by states on the same basis that they would consider any other health measure.

Mrs. Sanger said she recently interviewed 10 women whose husbands were going off to war. Eight of the 10 said they were going to have babies. Each gave the same reason.

"She wanted to have a baby by the man she liked."—San Francisco *News,* June 3.

* * *

Old Birth Control Ban Upheld

Connecticut's High Court Backs Law Against Practice

Hartford (Conn.), June 3.—(AP).—Upholding Connecticut's 63-year-old anti-birth control law for the second time in two years, the State supreme court ruled in a three to two decision today that it was illegal for a physician to advise a married woman to use contraceptives even when bearing a child might cost her life.

The case arose from a request by Dr. Wilder Tileston of Yale medical faculty, for a declaratory judgment as to whether the law prohibits a licensed physician from prescribing contraceptives for married women in cases where pregnancy would endanger life or health and, if so, whether the law is constitutional.

Both prescribing contraceptives and the use of them to avoid conception are criminal offenses under Connecticut law, but a physician can perform an abortion upon a married woman, if necessary to save her life.—San Francisco *Examiner,* June 4.

* * *

Supreme Court: Oklahoma Sterilization Law Is Ruled Unconstitutional

Washington, June 1. (AP).—Declaring that important questions of human rights were involved, the Supreme Court held unconstitutional today an Oklahoma law for the sterilization of certain habitual criminals.

The court struck down the statute because it singled out only certain types of criminals. Such "clear, pointed, unmistakable discrimination" was called as "invidious as if it had selected a particular race or nationality for oppressive treatment."

The act provides for the sterilization of men or women thrice convicted of felonies but specifically excepts "offenses arising out of the violation of the prohibitory laws, revenue acts, embezzlement or political offenses."

The case at issue involved Jack T. Skinner, 34, of Pittsburgh county, Oklahoma, who was convicted once of stealing chickens and twice of armed robbery and ordered in 1937 to be sterilized. The court pointed out that Oklahoma treats larcency and embezzlement the same as far as fines and prison terms are concerned and that if Skinner had embezzled the chickens as an employe of the owner instead of stealing them as a stranger, he would not have been subject to sterilization.

This situation, said the majority decision by Justice Douglas, violates the fourteenth amendment to the constitution which guarantees all citizens equal protection of the laws. There was no dissent, but Chief Justice Stone and Justice Jackson wrote separate concurring opinions.

"We are dealing here," Douglas writes, "with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race."

The court some years ago upheld a Virginia law for the sterilization of feeble-minded persons in State institutions. Twenty-seven States have laws for compulsory sterilization of "defective persons." Nine of them, California, Delaware, Idaho, Iowa, Nebraska, North Dakota, Washington, Oklahoma and Oregon, provide for sterilization of "habitual criminals," with varying definition of that phrase.—San Francisco *Chronicle,* June 2.

* * *

Spare the Doctor

Few realize the tremendous strain imposed on the medical profession by the war.

So many doctors have been drawn into war service

that those remaining in civilian practice find themselves able to keep pace with civilian requirements only by extending their efforts to the greatest degree.

As time and the war progress the shortage of medical service will become even more acute, and we all would do well, therefore, to heed the plea to "Spare the Doctor" issued by the San Francisco Medical Association.

The patient may help the doctor materially in extending his usefulness, the association points out, by going to the doctor's office rather than asking the doctor to call at the home, and by making calls as brief as possible and as infrequent as the patient's condition will permit. —San Francisco *Call-Bulletin*, June 9.

* * *

Mother's Consent to Operation Necessary

Washington High Court Divides, Upholds Parental Veto

Olympia, Wash., June 11.—Upholding state laws governing custody of a child, the Supreme Court today decided 6 to 3 that with the mother of Patricia Hudson, 11, rests the only authority to grant doctors permission to amputate the girl's arm.

The case was taken to the Supreme Court after Superior Judge William G. Long of Seattle ruled in favor of Patricia's four brothers and five sisters, who approved the operation. The girl's left arm, according to physicians, is ten times the size of her normal right arm and may result in death within a few years.

The girl's mother objected to the operation because she feared the operation might cause death. Doctors stated there is a fifty-fifty chance that the operation will prove successful and prolong the girl's life.

In reversing the lower court, the Supreme Court ruled that unless custody of the child was awarded to another guardian, the child could not be subjected to a surgical operation without the mother's consent.—Los Angeles *Daily-Journal*, June 12.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Operations Without Consent; Emergencies Created By War Conditions

IT IS a rule of very general application that a physician or surgeon who operates upon a person without his consent, express or implied, is guilty of an assault in the absence of extenuating circumstances, and must respond to the person operated upon in damages to compensate for any loss occasioned by such an unauthorized operation. Where a patient is in full possession of his faculties and in such physical health as to allow consultation with the physician or surgeon with respect to his condition, his consent is a prerequisite to even a minor operation if the physician or surgeon involved is to avoid liability for unforeseen damaging results of the operation.

Another ramification of this general rule is that the patient must be legally capable of giving his consent, and at this time two classes of persons are recognized by the law as being incapable of giving such consent, i.e., minors and mentally incompetent adults. (For a full discussion of operations upon persons legally incompetent to consent to same, see the Medical Jurisprudence article in the March, 1939, issue of CALIFORNIA AND WESTERN MEDICINE, Vol. 50, No. 3.) Consent to the performance of operations upon these persons must be obtained from those legally qualified to give such consent, in the case of a minor from his parents, if living, or from his duly-appointed guardian, and in the case of mental incompetents from their guardians.

These are the general rules applied in court actions brought by a person claiming to have been operated upon without his consent and injured thereby, but they are varied from time to time and a physician or surgeon is protected when he acts in cases of emergency to save life or limb. Also, in many cases, the courts will find from the facts that the patient has given his "implied consent" to the operation.

The rule is stated in *48 Corpus Juris*, at page 1131, that where an emergency arises calling for immediate action for the preservation of life or health of the person, and it is impracticable to obtain his consent or the consent of anyone authorized to speak for him, it is the duty of the physician or surgeon to operate if such action is necessary to save the person's life or preserve his health. In *Moss v. Rishworth, 222 S.W. 225*, a decision of the Texas Court of Appeal, the principle is very clearly set forth as follows:

"The authorities are unanimous in holding that a surgeon is liable for operating on a patient unless he obtains the consent of that patient, if competent to give such consent, or if not, of some one who under the circumstances would be legally authorized to give the requisite consent. If a person should be injured to the extent that he is unconscious and his injuries of such nature as to require prompt surgical attention, a physician called would be justified in applying such treatment as might be reasonably necessary for the preservation of his life or limb, and consent on the part of the injured person would be implied upon the ground of an existing emergency."

This rule is sometimes extended to include the expansion of an operation to which a patient has consented if, during the course of the operation, the surgeon discovers the presence of some other condition which requires immediate attention if the life of the patient is to be prolonged.

If the long-anticipated attack by the enemy upon the coast of California should occur, California physicians would undoubtedly be presented with a great number of cases where they would be required to determine whether the condition of a person injured by a bomb explosion, fire, etc., was such as to require immediate surgical treatment, and whether it would be safe from a legal standpoint to proceed with the treatment without waiting to obtain the consent of the person himself, should he be unconscious, or the parents or guardian, if the injured person should be a child. Whether a person's life or limb is actually endangered may be a difficult question of fact, and many times the physician would be compelled to ignore the possibility of subjecting himself to suit, if his experience and training indicated that immediate surgical treatment was necessary to save the life of the bombing victim.

It is the opinion of this writer that the general rules with respect to operations without consent

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

as set forth above would be applied in substantially the same manner during the war time emergency as during an analogous situation arising in times of peace. There is a complete lack of authority upon this subject, but it would seem that the war should have no legal effect upon the conduct of physicians or surgeons in times of emergency. Possibly, the intense strain under which a physician would be compelled to work during such times might incline the courts to be more lenient in case a court action was subsequently commenced against a physician by a bombing victim operated upon without his consent; but it can be said safely that the physician or surgeon in such times should conduct himself in substantially the same manner as he does when confronted with some serious accident, such as a train wreck or automobile collision. If the condition of the injured person is not such as to require immediate medical or surgical treatment, the physician should delay any surgery or other treatment until the consent of the proper persons can be obtained, but if immediate treatment is necessary to save life or limb, it would be his duty to administer such treatment.

HOSPITAL SURVEY

(Continued from Adv. Page 37)

There were 1,404,940 live births in hospitals during 1941, an increase of 190,448 over the previous year, which is by far the greatest increase recorded in this respect between any two consecutive years. There are nine states in which the number of births in hospitals exceeded 50,000, headed naturally by New York, which reported 180,037 births, followed by Pennsylvania with 112,392, Illinois with 99,997, California with 85,763, Ohio with 82,677, Michigan with 69,670, New Jersey with 60,761, Texas with 59,564 and Massachusetts with 57,642.

For the first time the census obtained data regarding the number of patients operated on in hospitals. During 1941, 5,201,650 patients or 44.86 per cent of those admitted to hospitals were operated on. The report points out that as would be expected the states of New York, Pennsylvania, Illinois, California, Ohio and Michigan, respectively, reported the highest number.

The report explains that the facilities omitted from the list of registered hospitals are of two types: first, those that follow methods and practices such as are generally recognized as unethical or dangerous and that therefore need complete change of policy before being recommended to the public. Their number at the present time is 542. Their capacity, according to the latest available information is 16,267 beds, or less than two thirds of 1 per cent of the facilities furnished by the hospitals recognized in the Register. A second class of facilities not appearing in the Register includes emergency stations, clinics, offices and so on, with some facilities for bed care attached or available. They are recognized as ethical and valuable auxiliary facilities to the hospital system. The bed capacity of these institutions, usually spoken of as unclassified, is too variable to be positively enumerated.

"In January, 1942," the report says, "a survey was made of the facilities for blood and plasma banks in the hospitals approved for internships, residencies and fellowships. Of the 1,070 approved hospitals 462, or 43.2 per cent, reported that such facilities were either in operation or in the process of being established. Some of these institutions also act as manufacturing and distributing centers to supply blood, plasma or serum to other hospitals in the vicinity. The reports also indicated that many hospitals have commercial products on hand to meet emergency needs."

It was found that 206 hospitals maintain both blood and plasma banks, with 17 others in the process of development. In addition there are 171 hospitals operating plasma banks and 33 separate institutions with blood banks. It was reported that nine additional blood banks are being established as well as twenty-six plasma banks.

The report says that the data serve "to emphasize the fact that hospital facilities must be provided not according to any abstract formula but in accordance with the requirements of the people in the community under consideration."

Report on Toxicity of Mapharsen.—A review of scientific literature since 1935 shows that mapharsen is less toxic than neoarsphenamine in the treatment of syphilis, Edward A. Levin, M. D., and Frances Keddie, M. D., San Francisco, report in *The Journal of the American Medical Association.*

"To date," the two physicians say, "only six fatalities from mapharsen have been reported. This rate is remarkably low considering that over twelve million ampules of mapharsen have been manufactured. The deaths were reported as due to kidney damage in 2 cases, hemorrhagic encephalitis in 1, aplastic anemia in 2, and agranulocytosis in 1. . . .

"About 90 per cent of the patients who have severe gastrointestinal reactions to the arsphenamines can tolerate mapharsen in therapeutic doses. . . .

"The United States Navy statistics on observations of reactions to neoarsphenamine and to mapharsen among patients comparable as to age, sex and general condition of health, indicate that mapharsen is definitely the less toxic."

MEDICAL EPONYM

Little's Disease

William John Little (1810-1894) wrote "On the Influence of Abnormal Parturition, Difficult Labours, Premature Birth and Asphyxia Neonatorum on the Mental and Physical Condition of the Child, Especially in Relation to Deformities" in the *Transactions of the Obstetrical Society of London* (3:293-344, 1862).

"Asphyxia neonatorum, through resulting injury to nervous centres, is the cause of the commonest contractions which originate at the moment of birth, namely, more or less general spastic rigidity, and sometimes of paralytic contraction.

"The former class of affections may be described as impairment of volition, with tonic rigidity and ultimately structural shortening, in varying degrees, of a few of many of the muscles of the body. Both lower extremities are more or less generally involved. . . . Sometimes the affection of one limb only is observed by the parent, but examination usually shows a smaller degree of affection in the limb supposed to be sound. The contraction in the hips, knees, and ankles, is often considerable. The flexors and adductors of thighs, the flexors of knees, and the gastrocnemii, preponderate. In most cases, after a time, owing to structural shortening of the muscles and of the articular surfaces, the thighs cannot be completely abducted or extended, the knees cannot be straightened, nor can the heels be properly applied to the ground. The upper extremities are sometimes held down by preponderating action of pectorals, teres major and teres minor, and latissimus dorsi; the elbows are semi-flexed, the wrists partially flexed, pronated, and the fingers incapable of perfect voluntary direction."—R. W. B., in *New England Journal of Medicine.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 7, July, 1917

EXCERPTS FROM EDITORIAL NOTES

Druggists' Commissions.—There have already developed interesting features as a result of our editorial, "There Be Land Rats and Water Rats," attacking, in the last issue, the exchange of commissions between the physician and the bandagist. We have been assured by certain druggists that the giving of commissions to physicians, in return for prescription business, is greatly on the wane, but still exists, and that the druggists see no way out. They are ashamed of this phase of their business and would like to see it abolished, but evidently they are so poorly organized that they cannot hang together and put through a reform of this sort. But the druggists are not the only culprits. There are, and we say it regretfully, those among our own ranks who not only accept commissions, but insist upon them. . . .

On the heels of this statement, one pharmacy has done that very thing. It has a printed circular which it has mailed to many physicians, and which will be wrapped with each package, so that the patient may know what is going on. This circular reads, "Our institution is entirely individual and has no financial or pecuniary connection with any physician. If the doctor directs you to have your prescription work done by us, he does it solely for the reason that he knows we can be absolutely depended upon to dispense exactly what he orders. . . . All of which proves that he has your interest at heart."

That is the milk in the cocoanut.

Read This—It Is For Your Benefit!—You have had it drummed into you until you are sick of it, that to help the JOURNAL you must patronize its advertisers. Now we are asking your help to get advertisements. . . .

Our Legal Records and the Indemnity Defense Fund.—The practice of medicine depends perhaps more than any other branch of scientific endeavor upon experiment and inductive reasoning. And yet it is very difficult to direct the attention of men of this type of mind to matters of intense personal interest to them. We refer to the records of our Legal Department.

These records of claim after claim, and case after case against physicians, should engage the careful consideration of every member. They show conclusively, first, that neglect, carelessness, and lack of skill are not charged only against the younger men, the more inexperienced men, and the men who might not be termed the most learned or careful in any given line of work. But, on the contrary, these records demonstrate that these claims are made and suits are brought with the greatest impartiality against the most experienced, the most skilful, and the most careful of those of whom the profession can boast.

Secondly, these files show that rapacity and ignorance refuse to recognize that man is mortal; that there are few specific remedies; in a word, that a physician is not a warrantor of cures, nor a guarantor of diagnosis and treatment.

(Continued in Front Advertising Section, Page 18)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

Board Proceedings

At the special meeting of the Board held in San Francisco, April 19, 1942, Fred R. DeLappe, M. D., of Modesto, was elected President, and Percival Dolman, M. D., of San Francisco, was elected Vice-President.

News

"Judge James William Morgan yesterday fined T. H. Lee, 627 Main Street, $100 for violation of the medical practice act, and sentenced him to six months in the county jail, later suspended on condition he refrain from practicing medicine. He was arrested April 14, following an alleged attempted axe attack upon a woman and her husband, who had demanded the return of $40.00 which they had paid for ineffective medicine." (Chico *Record*, May 7. 1942.)

"Charges against Dr. Roy L. Buffum, prominent Long Beach physician, of performing an illegal operation, were recommended dismissed by the prosecution yesterday after the doctor's two codefendants had pleaded guilty to a similar charge before Superior Judge A. A. Scott. Pleading guilty were Dr. J. J. Tobinsky, whose license has been revoked, and his office manager, J. C. Martin. They applied for probation and their hearing was set for June 16. Dr. Tobinsky and Martin were arrested last Jan. 16. Dr. Buffum was taken into custody at the same time and accused of having sent women patients to Tobinsky. Deputy District Attorney John Hopkins, however, told the court that there is not sufficient evidence to warrant trial of Dr. Buffum." (Los Angeles *Herald and Express*, May 19, 1942.)

"Have a yen, now and then, for a letter? Does the postman pass you by? There's a simple solution. Just apply for a marriage license. You'll get lots of mail. . . . Of first importance is compliance with California's medical examination law. Blood tests and health certificates are available from $1.40 per person up, you learn in bold, black type, and every laboratory guarantees hurry-up, 24-hour service. . . ." (Santa Monica *Outlook*, May 13, 1942.)

"Charged with having engineered abortions for unmarried women, Mrs. Carmen Cantu, 40, of 1219 West Second St., Santa Ana, was jailed by District Attorney George F. Holden's investigators and Santa Ana police late yesterday. . . ." (Orange *News*, May 13, 1942.)

"Physicians living permanently in California, but not licensed in this state, may not use social calling cards carrying the designation 'Doctor' or 'M.D.', Attorney General Earl Warren has advised the State Board of Medical Examiners. Warren's opinion said that for many physicians the calling card is the only means of 'holding

(Continued in Back Advertising Section, Page 31)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.